AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
RUC RECOMMENDATIONS FOR CPT 2023
October 2021 Meeting

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AMA
AMERICAN MEDICAL ASSOCIATION

ama-assn.org
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October 26, 2021

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Subject: RUC Recommendations

Dear Administrator Brooks-LaSure,

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

Enclosed are the RUC recommendations for all the CPT codes reviewed at the October 6-9, 2021, RUC meeting.

COVID-19 Immunization Administration
The CPT Editorial Panel has implemented CPT codes to describe immunization administration of vaccines developed by each of the following: Pfizer-BioNTech, Moderna, AstraZeneca, Janssen and Novavax. RUC recommendations related to Pfizer-BioNTech and Moderna were submitted to CMS in December 2020. We submitted our recommendations for immunization administration of the AstraZeneca in late January 2021 with the RUC comment letter on the Final Rule for 2021. We submitted the Janssen immunization administration recommendations in February 2021 and the Novavax immunization administration recommendation in May 2021. We submitted the recommendations for the Pfizer-BioNTech booster, Moderna booster, Pfizer Tris-Sucrose formulation and Pfizer Tris-Sucrose age 5-11 immunization administration on October 15, 2021, and are including them along with all nineteen COVID-19 immunization administration recommendations to date with this submission.

CPT 2023 New and Revised Codes – *October 2021 RUC Submission*
The RUC submits work value and/or practice expense inputs for 56 new/revised/related family CPT codes for *CPT 2023* from the April 2021 RUC meeting.

Existing Services Identified by RUC and CMS for Review
In addition to the new/revised CPT code submission, the RUC submits recommendations for 2 services identified by the RUC or CMS as potentially misvalued and reviewed at the October 2021 RUC meeting.

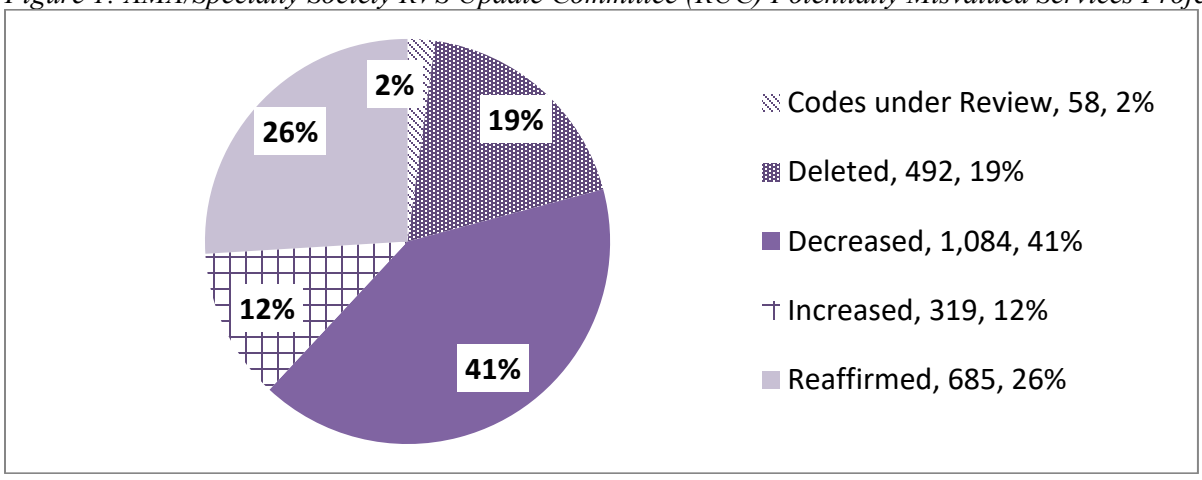
Office Visits Included in Codes with a Surgical Global Period

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

RUC Progress in Identifying and Reviewing Potentially Misvalued Codes

Since 2006, the RUC has identified 2,638 potentially misvalued services through objective screening criteria and has completed review of 2,580 of these services. The RUC has recommended that 60% of the services reviewed be decreased or deleted (Figure 1). The RUC has worked vigorously to identify and address mis-valuations in the RBRVS through the provision of revised physician time data and resource recommendations to CMS. The RUC looks forward to working with CMS on a concerted effort to address potentially misvalued services.

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



Source: American Medical Association

Potential Misreporting (Somatic Nerve Injections)
The RUC identified potential misreporting for CPT codes 64445 *Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed* and 64447 *Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed*. The 2019 Medicare utilization data indicates that family physicians are the dominant specialty in the non-facility setting for these two codes, reporting at 36% and 57% respectively. The reporting of these services by family physicians is confusing as these are not procedures that would typically be provided by non-anesthesiologists. Upon further research, the specialties determined that the family medicine non-facility reporting these services are likely a result of inappropriate reporting. The public 2019 Physician Supplier Procedure Summary (PSPS) file was analyzed, and it was found that family medicine physicians in Fort Worth, Texas were responsible for 64% of all claims for CPT code 64445 and 89% of all claims for CPT code 64447. The large concentration of family medicine non-facility claims in one locality suggests potential misreporting. The RUC suggests that CMS explore and address this issue.

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

Bubble Contrast Supply Item
The RUC determined that SD332 *bubble contrast*, an ultrasound-specific contrast agent, should be removed from the supply inputs for CPT codes 76978 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion* and 76979 *Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (List separately in addition to code for primary procedure)*. This supply item is not necessary because contrast agents are reported separately via temporary Q codes. The contrast agent used for these procedures is separately reported using existing HCPCS Level II supply codes, such as Q9950 *Injection, sulfur hexafluoride lipid microspheres, per ml*. **The RUC requests that CMS remove supply code SD332 *bubble contrast* from CPT codes 76978 and 76979 and from the direct PE inputs medical supplies listing.** *See attached ACR letter.*

Enclosed Recommendations and Supporting Materials:

- RUC Recommendation Status Report for New and Revised Codes for *CPT 2023*.
- RUC Recommendation Summary of Existing Codes Identified by CMS or the Relativity Assessment Workgroup.
- RUC Recommendation Progress and Status Reports for 2,638 services identified to date by the Relativity Assessment Workgroup and CMS as potentially misvalued.
- RUC Referrals to the CPT Editorial Panel – both for CPT nomenclature revisions and *CPT Assistant* articles.

- Physician Time File – A list of the physician time data for each of the CPT codes reviewed at the October 2021 RUC meeting.

- Pre-Service and Post-Service Time Packages Definitions – The RUC developed physician pre-service and post-service time packages which have been incorporated into these recommendations. The intent of these packages is to streamline the RUC review process as well as create standard pre-service and post-service time data for all codes reviewed by the RUC.

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

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

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

- New Technology List and Timeline – In April 2006, the RUC adopted a process to identify and review codes that represent new technology or services that have the potential to change in value. To date, the RUC has identified 750 of these procedures through the review of new CPT codes. A table of these codes identified as new technology services and the date of review is enclosed, as well as a flow chart providing a detailed description of the process to be utilized to review these services.

- RUC Recommendations on Modifications to Visits in the Global Period – *There are no recommendations in this submission that include office visits in the global period, therefore there is not a file for this submission. We will continue to track and submit for future recommendations.*

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

Sincerely,

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

Enclosures

cc: RUC Participants
Perry Alexion, MD
Larry Chan
Arkaprava Deb, MD
Edith Hambrick, MD
Ryan Howe
Scott Lawrence
Karen Nakano, MD
Michael Soracoe
Gift Tee

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

RESOURCE MATERIALS
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CPT 2023 RUC and HCPAC Recommendations

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
157X1	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C1	April 2021	09	ACS, ASCRS, SAGES	8.50	8.00		☑		☐
338X3	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A1	October 2021	04	ACC, SCAI	14.00	14.00		☑		☑
338X4	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A2	October 2021	04	ACC, SCAI	18.00	18.00		☑		☑
338X5	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A3	October 2021	04	ACC, SCAI	17.33	17.33		☑		☑
338X6	000	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A4	October 2021	04	ACC, SCAI	20.00	20.00		☑		☑
338X7	ZZZ	N	Feb 2021	15	Endovascular Pulmonary Arterial Revascularization	A5	October 2021	04	ACC, SCAI	7.27	7.27		☑		☑
43235	000	F	Feb 2021	16	Endoscopic Bariatric Device Procedures	B1	April 2021	08	ACG, AGA, ASGE, SAGES	2.09	2.09	Yes	☑		☐
43X21	000	N	Feb 2021	16	Endoscopic Bariatric Device Procedures	B2	April 2021	08	ACG, AGA, ASGE, SAGES	3.40	3.11		☑		☑
43X22	000	N	Feb 2021	16	Endoscopic Bariatric Device Procedures	B3	April 2021	08	ACG, AGA, ASGE, SAGES	2.80	2.80		☑		☑
49560	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49561	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49565	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49566	090	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐
49568	ZZZ	D	Feb 2021	18	Anterior Abdominal Hernia Repair		Deleted						☑		☐

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

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
49X05	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C6	April 2021	09	ACS, ASCRS, SAGES	17.00	14.88		☑		☐
49X06	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C7	April 2021	09	ACS, ASCRS, SAGES	24.24	20.00		☑		☐
49X07	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C8	April 2021	09	ACS, ASCRS, SAGES	7.75	7.75		☑		☐
49X08	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C9	April 2021	09	ACS, ASCRS, SAGES	10.79	10.79		☑		☐
49X09	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C10	April 2021	09	ACS, ASCRS, SAGES	12.00	12.00		☑		☐
49X10	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C11	April 2021	09	ACS, ASCRS, SAGES	18.50	16.50		☑		☐
49X11	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C12	April 2021	09	ACS, ASCRS, SAGES	18.53	16.97		☑		☐
49X12	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C13	April 2021	09	ACS, ASCRS, SAGES	25.00	24.00		☑		☐
49X13	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C14	April 2021	09	ACS, ASCRS, SAGES	15.50	14.24		☑		☐
49X14	000	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C15	April 2021	09	ACS, ASCRS, SAGES	20.25	18.00		☑		☐
49X15	ZZZ	N	Feb 2021	18	Anterior Abdominal Hernia Repair	C16	April 2021	09	ACS, ASCRS, SAGES	5.00	5.00		☑		☐
64400	000	F	May 2021	14	Somatic Nerve Injections	M1	October 2021	05	AAN, AAPM, AAPM&R, ASA, SIS	1.00	1.00		☑		☐
64405	000	F	May 2021	14	Somatic Nerve Injections	M2	October 2021	05	AAN, AAPM, AAPM&R, ASA, NANS, SIS	0.94	0.94	Yes	☑		☐
64408	000	F	May 2021	14	Somatic Nerve Injections	M3	October 2021	05	ASA, NANS, SIS	0.90	0.90		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
64415	000	R	May 2021	14	Somatic Nerve Injections	M4	October 2021	05	ASA, ASIPP	1.50	1.50		☑		☐
64416	000	R	May 2021	14	Somatic Nerve Injections	M5	October 2021	05	ASA, ASIPP	1.80	1.80		☑		☐
64417	000	R	May 2021	14	Somatic Nerve Injections	M6	October 2021	05	ASA, ASIPP	1.31	1.31		☑		☐
64418	000	F	May 2021	14	Somatic Nerve Injections	M7	October 2021	05	ASA, NANS, SIS	1.10	1.10	Yes	☑		☐
64420	000	F	May 2021	14	Somatic Nerve Injections	M8	October 2021	05	AAPM, AAPM&R, ASA NANS, SIS	1.18	1.18		☑		☐
64421	ZZZ	F	May 2021	14	Somatic Nerve Injections	M9	October 2021	05	AAPM, AAPM&R, ASA, NANS, SIS	0.60	0.60		☑		☐
64425	000	F	May 2021	14	Somatic Nerve Injections	M10	October 2021	05	AAPM, AAPM&R, ASA, NANS, SIS	1.19	1.19		☑		☐
64430	000	F	May 2021	14	Somatic Nerve Injections	M11	October 2021	05	ASA, NANS, SIS	1.15	1.15		☑		☐
64435	000	F	May 2021	14	Somatic Nerve Injections	M12	October 2021	05	ASA, NANS, SIS	0.75	0.75	Yes	☑		☐
64445	000	R	May 2021	14	Somatic Nerve Injections	M13	October 2021	05	AAPM, AAPM&R, ASA, ASIPP	1.39	1.39		☑		☐
64446	000	R	May 2021	14	Somatic Nerve Injections	M14	October 2021	05	ASA, ASIPP	1.75	1.75		☑		☐
64447	000	R	May 2021	14	Somatic Nerve Injections	M15	October 2021	05	ASA, ASIPP	1.34	1.34		☑		☐
64448	000	R	May 2021	14	Somatic Nerve Injections	M16	October 2021	05	ASA, ASIPP	1.68	1.68		☑		☐
64449	000	F	May 2021	14	Somatic Nerve Injections	M17	October 2021	05	ASA, NANS, SIS	1.55	1.55		☑		☐
64450	000	F	May 2021	14	Somatic Nerve Injections	M18	October 2021	05	AAPM, AAPM&R, APMA, ASA, NANS, SIS	0.75	0.75	Yes	☑		☐

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64451	000	F	May 2021	14	Somatic Nerve Injections	M19	October 2021	05	AAPM, AAPM&R, ASA, NANS, SIS	1.52	1.52	Yes	☑		☐
64454	000	F	May 2021	14	Somatic Nerve Injections	M20	October 2021	05	AAPM, AAPM&R, ASA, ASA,NANS, SIS	1.52	1.52	Yes	☑		☐
64455	000	F	May 2021	14	Somatic Nerve Injections	M21	October 2021	05	APMA, NANS, SIS	0.75	0.75	Yes	☑		☐
69714	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N1	October 2021	06	AAOHNS				☑	Resurvey for January 2022	☐
69715	090	D	May 2021	13	Transcutaneous Passive Implant-Temporal Bone		Deleted						☑		☐
69716	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N2	October 2021	06	AAOHNS				☑	Resurvey for January 2022	☐
69717	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N4	October 2021	06	AAOHNS				☑	Resurvey for January 2022	☐
69718	090	D	May 2021	13	Transcutaneous Passive Implant-Temporal Bone		Deleted						☑		☐
69719	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N5	October 2021	06	AAOHNS				☑	Resurvey for January 2022	☐
69726	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N7	October 2021	06	AAOHNS				☑	Resurvey for January 2022	☐
69727	090	R	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N8	October 2021	06	AAOHNS				☑	Resurvey for January 2022	☐
69XX0	090	N	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N3	October 2021	06	AAOHNS				☑	Resurvey for January 2022	☐
69XX1	090	N	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N6	October 2021	06	AAOHNS				☑	Resurvey for January 2022	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
69XX2	090	N	May 2021	13	Transcutaneous Passive Implant-Temporal Bone	N9	October 2021	06	AAOHNS				☑	Resurvey for January 2022	☐
76942	XXX	R	May 2021	14	Somatic Nerve Injections	M22	October 2021	05	AAPM, AAPM&R, ACR, SIR, SIS AAPM&R	0.67	0.67	Yes	☑		☐
77002	ZZZ	R	May 2021	14	Somatic Nerve Injections	M23	October 2021	05	AAPM, AAPM&R, ACR, SIR, SIS AAPM&R	0.54	0.54	Yes	☑		☐
77003	ZZZ	R	May 2021	14	Somatic Nerve Injections	M24	October 2021	05	ACR, SIR, SIS	0.60	0.60	Yes	☑		☐
92065	XXX	R	Feb 2021	35	Orthoptic Training	D1	April 2021	10	AAO, AOA	0.71	0.71		☑		☑
920XX	XXX	N	Feb 2021	35	Orthoptic Training	D2	April 2021	10	AAO, AOA				☑	PE Only	☑
92284	XXX	R	May 2021	EC-M	Dark Adaptation Examination		Editorial			0.24	0.24	Yes	☑		☐
93563	ZZZ	R	May 2021	36	Pulmonary Angiography	P1	October 2021	08	ACC, SCAI	1.11	1.11	Yes	☑		☐
93564	ZZZ	R	May 2021	36	Pulmonary Angiography	P2	October 2021	08	ACC, SCAI	1.13	1.13	Yes	☑		☐
93565	ZZZ	R	May 2021	36	Pulmonary Angiography	P3	October 2021	08	ACC, SCAI	0.86	0.86	Yes	☑		☐
93566	ZZZ	R	May 2021	36	Pulmonary Angiography	P4	October 2021	08	ACC, SCAI	0.86	0.86	Yes	☑		☐
93567	ZZZ	R	May 2021	36	Pulmonary Angiography	P5	October 2021	08	ACC, SCAI	0.97	0.97	Yes	☑		☐
93568	ZZZ	R	May 2021	36	Pulmonary Angiography	P6	October 2021	08	ACC, SCAI	0.88	0.88	Yes	☑		☐
93XX0	ZZZ	N	May 2021	36	Pulmonary Angiography	P7	October 2021	08	ACC, SCAI	1.05	1.05		☑		☑
93XX1	ZZZ	N	May 2021	36	Pulmonary Angiography	P8	October 2021	08	ACC, SCAI	1.75	1.75		☑		☑
93XX2	ZZZ	N	May 2021	36	Pulmonary Angiography	P9	October 2021	08	ACC, SCAI	1.84	1.84		☑		☑
93XX3	ZZZ	N	May 2021	36	Pulmonary Angiography	P10	October 2021	08	ACC, SCAI	1.92	1.92		☑		☑

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
959XX	XXX	N	May 2021	27	Quantitative Pupillometry Services	Q1	October 2021	09	AAO, AAP	0.25	0.25		☑		☑
96X70	XXX	N	Feb 2021	39	Caregiver Behavior Management Training	E1	April 2021	11	AACAP, AND, APA (Psychology)	0.50	0.43		☑		☐
96X71	ZZZ	N	Feb 2021	39	Caregiver Behavior Management Training	E2	April 2021	11	AACAP, AND, APA (Psychology)	0.17	0.12		☑		☐
97150	XXX	R	May 2021	28	Therapeutic Procedures Work Hardening Therapeutic Procedures Work Hardening		Editorial			0.29	0.29	Yes	☑		☐
97545	XXX	R	May 2021	28	Therapeutic Procedures Work Hardening Therapeutic Procedures Work Hardening	R1	Editorial						☑		☐
97546	XXX	R	May 2021	28	Therapeutic Procedures Work Hardening Therapeutic Procedures Work Hardening	R2	Editorial						☑		☐
99217	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99218	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99219	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99220	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99221	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F1	October 2021	10	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS				☑	Resurvey for January 2022	☐
99222	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F2	October 2021	10	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS				☑	Resurvey for January 2022	☐
99223	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F3	October 2021	10	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS				☑	Resurvey for January 2022	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99224	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99225	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99226	XXX	D	Feb 2021	06	Inpatient and Observation Care Services		Deleted						☑		☐
99231	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F4	October 2021	10	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS				☑	Resurvey for January 2022	☐
99232	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F5	October 2021	10	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS				☑	Resurvey for January 2022	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99233	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F6	October 2021	10	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS				☑	Resurvey for January 2022	☐
99234	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F7	October 2021	10	AAHPM, AAN, AAOS, AAP, AATS, ACC, ACOG, ACP, AGS, ANA, ATS, CHEST, IDSA, NASS, SHM, STS				☑	Resurvey for January 2022	☐
99235	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F8	October 2021	10	AAHPM, AAN, AAOS, AAP, AATS, ACC, ACOG, ACP, AGS, ANA, ATS, CHEST, IDSA, NASS, SHM, STS				☑	Resurvey for January 2022	☐
99236	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F9	October 2021	10	AAHPM, AAN, AAOS, AAP, AATS, ACC, ACOG, ACP, AGS, ANA, ATS, CHEST, IDSA, NASS, SHM, STS				☑	Resurvey for January 2022	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99238	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F10	October 2021	10	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS				☑	Resurvey for January 2022	☐
99239	XXX	R	Feb 2021	06	Inpatient and Observation Care Services	F11	October 2021	10	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACOG, ACP, ACS, AGS, ANA, ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, IDSA, NASS, SAGES, SHM, STS, SVS				☑	Resurvey for January 2022	☐
99241	XXX	D	Feb 2021	07	Consultations		Deleted						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99242	XXX	R	Feb 2021	07	Consultations	G1	October 2021	12	AADA, AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SNMMI, STS, SVS	1.08	1.08		☑		☐
99243	XXX	R	Feb 2021	07	Consultations	G2	October 2021	12	AADA, AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SNMMI, STS, SVS	1.80	1.80		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99244	XXX	R	Feb 2021	07	Consultations	G3	October 2021	12	AADA, AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SNMMI, STS, SVS	2.80	2.69		☑		☐
99245	XXX	R	Feb 2021	07	Consultations	G4	October 2021	12	AADA, AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SNMMI, STS, SVS	3.75	3.75		☑		☐
99251	XXX	D	Feb 2021	07	Consultations		Deleted						☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99252	XXX	R	Feb 2021	07	Consultations	G5	October 2021	12	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS				☑	Resurvey for January 2022	☐
99253	XXX	R	Feb 2021	07	Consultations	G6	October 2021	12	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS				☑	Resurvey for January 2022	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99254	XXX	R	Feb 2021	07	Consultations	G7	October 2021	12	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS				☑	Resurvey for January 2022	☐
99255	XXX	R	Feb 2021	07	Consultations	G8	October 2021	12	AAHPM, AAN, AANS, AAOS, AAP, AATS, ACC, ACG/AGA/ASGE, ACNM, ACOG, ACRh, ACS, APA (psychiatry), ASCO, ASCRS (colon), ASSH, ATS, CHEST, CNS, NASS, SAGES, SNMMI, STS, SVS				☑	Resurvey for January 2022	☐
99281	XXX	R	Feb 2021	08	Emergency Department Services	H1	April 2021	12	AAP, ACEP, ANA	0.25	0.25		☑		☐
99282	XXX	R	Feb 2021	08	Emergency Department Services	H2	April 2021	12	AAP, ACEP, ANA	0.93	0.93	Yes	☑		☐
99283	XXX	R	Feb 2021	08	Emergency Department Services	H3	April 2021	12	AAP, ACEP, ANA	1.60	1.60	Yes	☑		☐
99284	XXX	R	Feb 2021	08	Emergency Department Services	H4	April 2021	12	AAP, ACEP, ANA	2.74	2.60		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99285	XXX	R	Feb 2021	08	Emergency Department Services	H5	April 2021	12	AAP, ACEP, ANA	4.00	4.00	Yes	☑		☐
99304	XXX	R	Feb 2021	09	Nursing Facility Services	I1	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	1.60	1.50		☑		☐
99305	XXX	R	Feb 2021	09	Nursing Facility Services	I2	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	2.50	2.50		☑		☐
99306	XXX	R	Feb 2021	09	Nursing Facility Services	I3	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	3.50	3.50		☑		☐
99307	XXX	R	Feb 2021	09	Nursing Facility Services	I4	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	0.70	0.70		☑		☐
99308	XXX	R	Feb 2021	09	Nursing Facility Services	I5	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	1.30	1.30		☑		☐
99309	XXX	R	Feb 2021	09	Nursing Facility Services	I6	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	1.92	1.92		☑		☐
99310	XXX	R	Feb 2021	09	Nursing Facility Services	I7	April 2021	13	AAPM&R, ACP, AGS, AMDA, ANA, APMA (99304 only)	2.80	2.80		☑		☐
99315	XXX	F	Feb 2021	09	Nursing Facility Discharge Day Management Services	I8	October 2021	11	AAPM&R, ACP, AGS, AMDA, ANA	1.50	1.50		☑		☐
99316	XXX	F	Feb 2021	09	Nursing Facility Discharge Day Management Services	I9	October 2021	11	AAPM&R, ACP, AGS, AMDA, ANA	2.50	2.50		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99318	XXX	D	Feb 2021	09	Nursing Facility Services		Deleted						☑		☐
99324	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99325	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99326	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99327	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99328	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99334	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99335	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99336	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99337	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99339	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99340	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99341	XXX	R	Feb 2021	10	Home and Residence Services	J1	October 2021	13	AAHPM, AGS, ANA, APMA	1.50	1.00		☑		☐
99342	XXX	R	Feb 2021	10	Home and Residence Services	J2	October 2021	13	AAHPM, AGS, ANA, APMA	2.00	1.65		☑		☐
99343	XXX	D	Feb 2021	10	Home and Residence Services		Deleted						☑		☐
99344	XXX	R	Feb 2021	10	Home and Residence Services	J3	October 2021	13	AAHPM, AGS, ANA	3.50	2.87		☑		☐
99345	XXX	R	Feb 2021	10	Home and Residence Services	J4	October 2021	13	AAHPM, AGS, ANA	4.00	3.88		☑		☐
99347	XXX	R	Feb 2021	10	Home and Residence Services	J5	October 2021	13	AAHPM, AGS, ANA, APMA	1.30	0.90		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99348	XXX	R	Feb 2021	10	Home and Residence Services	J6	October 2021	13	AAHPM, AGS, ANA, APMA	1.92	1.50		☑		☐
99349	XXX	R	Feb 2021	10	Home and Residence Services	J7	October 2021	13	AAHPM, AGS, ANA	2.70	2.44		☑		☐
99350	XXX	R	Feb 2021	10	Home and Residence Services	J8	October 2021	13	AAHPM, AGS, ANA	3.55	3.60		☑		☐
99354	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient		Deleted						☑		☐
99355	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient		Deleted						☑		☐
99356	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient		Deleted						☑		☐
99357	ZZZ	D	Feb 2021	11	Prolonged Services - with Direct Patient		Deleted						☑		☐
99358	XXX	F	Feb 2021	11	Prolonged Services - Without Direct Patient	K1	October 2021	14	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS	1.80	1.80		☑		☐
99359	ZZZ	F	Feb 2021	11	Prolonged Services - Without Direct Patient	K2	October 2021	14	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS	1.00	0.75		☑		☐
993X0	ZZZ	N	Feb 2021	11	Prolonged Services - On the Date of an E/M	K6	October 2021	15	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, SHM, STS				☑	Resurvey for January 2022	☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service
99415	ZZZ	F	Feb 2021	11	Prolonged Services - Clinical Staff Services (PE	K3	April 2021	15	AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS				☑	PE Only	☐
99416	ZZZ	F	Feb 2021	11	Prolonged Services - Clinical Staff Services (PE	K4	April 2021	15	AAHPM, AAP, ACP, AGS, ANA, ASCO, ATS, CHEST, SVS				☑	PE Only	☐
99417	ZZZ	R	Feb 2021	11	Prolonged Services - On the Date of an E/M	K5	October 2021	15	AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS				☑	Resurvey for January 2022	☐
99446	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial			0.35	0.35	Yes	☑		☐
99447	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial			0.70	0.70	Yes	☑		☐
99448	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial			1.05	1.05	Yes	☑		☐
99449	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial			1.40	1.40	Yes	☑		☐
99451	XXX	R	May 2021	06	Non-Face-to-Face Interprofessional Consultations		Editorial			0.70	0.70	Yes	☑		☐
99483	XXX	R	Feb 2021	11	Cognitive Assessment and Care Plan Services	L1	April 2021	16	AAN, ACP, AGS	3.80	3.50		☑		☐

CPT Code	Global Period	Coding Change	CPT Date	CPT Tab	Issue	Tracking Number	RUC Date	RUC Tab	S.S.	Original Specialty Rec	RUC Rec	Same RVU as last year?	MFS?	Comments	New Tech/Service

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

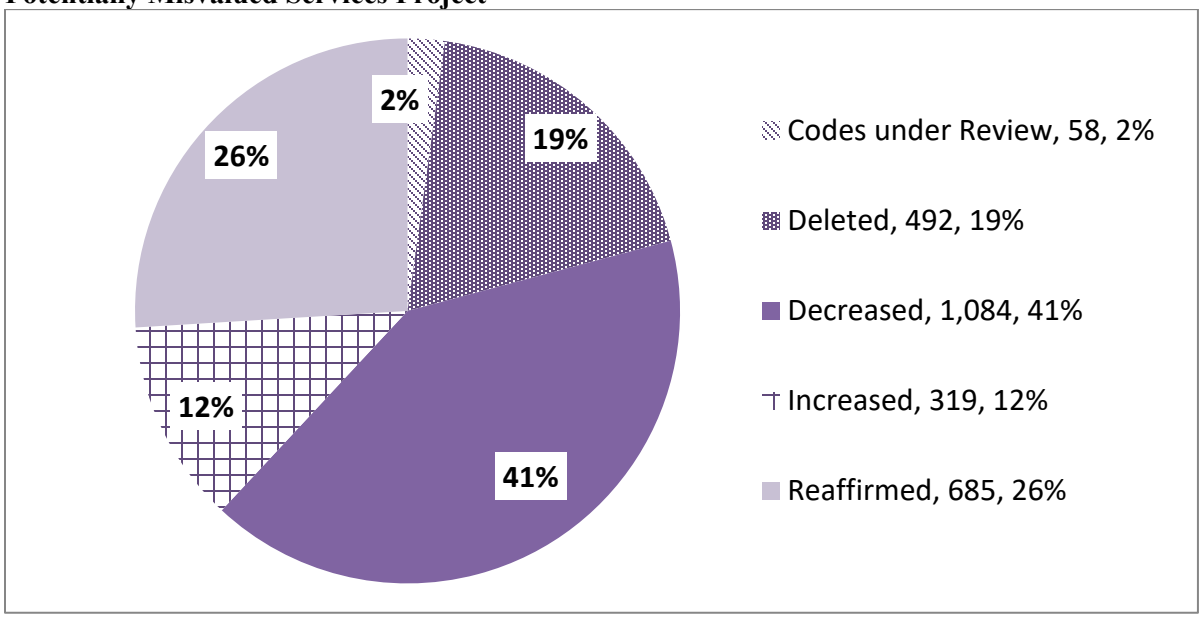
CPT Code	Long Descriptor	Issue	Tab	RUC Recommendation	CMS Request - Final Rule for 2020	CPT Assistant Analysis	High Volume Growth
73580	Radiologic examination, knee, arthrography, radiological supervision and interpretation	Contrast X-Ray of Knee Joint	16	0.59		X	X
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	3D Rendering with Interpretation and Report	17	0.79	X		

The RUC Relativity Assessment Workgroup Progress Report

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

To provide Medicare with reliable data on how physician work has changed over time, the RUC, with more than 300 experts in medicine and research, are examining 2,638 potentially misvalued services accounting for $45 billion in Medicare spending. The update committee has recommended reductions and deletions to 1,576 services, redistributing $5 billion annually. Here are the outcomes for the committee's review of 2,638 codes:

Potentially Misvalued Services Project



Source: American Medical Association

New Technology

As the RUC identifies new technology services that should be re-reviewed, a list of these services is maintained and forwarded to CMS. Currently, codes are identified as new technology based on recommendations from the appropriate specialty society and consensus among RUC members at the time of the RUC review for these services. RUC members consider several factors to evaluate potential new technology services, including recent FDA-approval, newness or novelty of the service, use of an existing service in a new or novel way, and migration of the service from a Category III to Category I CPT® code. The Relativity Assessment Workgroup maintains and develops all standards and procedures associated with the list, which currently contains 750 services. In September 2010, the re-review cycle began and since then the RUC has recommended 52 services to be re-examined. The remaining services are rarely performed (i.e., less than 500 times per year in the Medicare population) and will not be further examined. The Workgroup will continue to review the remaining 276 services every January after three years of Medicare claims data is available for each service.

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

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

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

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

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

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

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

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

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

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

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

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

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

High Volume Growth

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

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

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

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

resources required to provide these services. The RUC will review one service after additional utilization data is collected. The CPT Editorial Panel deleted 12 codes and the RUC submitted recommendations for 17 services for the 2017-2020 Medicare Physician Payment Schedules.

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

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

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

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

CMS Fastest Growing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Post-Operative Visits

010-Day Global Codes

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

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

090-Day Global Codes

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

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

High Level E/M in Global Period

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Final Rule for 2020
In the Final Rule for 2020, the public and CMS nominated 10 services as potentially misvalued, which was expanded to 14 services as part of the family. The RUC submitted recommendations for 11 services for the 2021 and 2023 Medicare Physician Payment Schedules. The RUC could not submit a recommendation for one code as it was determined it was not adequately described to evaluate. The RUC will review the remaining two services for the 2023 Medicare Physician Payment Schedule.

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

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

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

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

CMS Requests and RUC Relativity Assessment Workgroup Code Status

Total Number of Codes Identified*	**2,638**
Codes Completed	**2,580**
Work and PE Maintained	685
Work Increased	319
Work Decreased	905
Direct Practice Expense Revised (beyond work changes)	179
Deleted from CPT®	492
Codes Under Review	**58**
Referred to CPT® Editorial Panel or CPT Assistant	18
RUC to Review for *CPT 2023*	9
RUC to review future review after additional data obtained	31

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

RUC Recommendation: 4 base units **Referred to CPT** September 2016 **Result:** Decrease

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

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

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

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

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

RUC Recommendation: 3 base units **Referred to CPT** September 2016 **Result:** Decrease

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

01937 **Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic**

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

01938 **Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral**

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

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

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

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

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

01939 **Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic**

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

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

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

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

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

01940 **Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral**

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

01941 **Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic**

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

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

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

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

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

01942 **Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral**

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

First Identified: October 2019

2019 est Medicare Utilization: 5,679

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

RUC Recommendation: Maintain

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

Result: Maintain

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

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

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

First Identified: October 2019

2019 est Medicare Utilization: 12

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

RUC Recommendation: Maintain

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

Result: Maintain

0509T **Electroretinography (erg) with interpretation and report, pattern (perg)**

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

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

First Identified: October 2020

2019 est Medicare Utilization: 41,106

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

RUC Recommendation: Review action plan

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

Result: Remove from Screen

0671T **Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more**

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

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

First Identified: January 2021

2019 est Medicare Utilization:

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

RUC Recommendation: Contractor Price

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

Result: Contractor Price

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

First Identified: June 2017 **2019 est Medicare Utilization:** 503

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

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

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

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

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

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

First Identified: June 2017 **2019 est Medicare Utilization:** 145,323

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

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Decrease

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

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

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

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

First Identified: June 2017 **2019 est Medicare Utilization:** 33,658

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

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

11040 **Deleted from CPT**

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

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

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

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

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

11041 **Deleted from CPT**

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

First Identified: January 2012

2019 est Medicare Utilization: 46,378

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

RUC Recommendation: 1.80

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

Result: Increase

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

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

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

First Identified: January 2012

2019 est Medicare Utilization: 8,180

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

RUC Recommendation: 2.00

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

Result: Increase

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

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

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

First Identified: October 2010

2019 est Medicare Utilization: 837,707

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

RUC Recommendation: 0.17

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

Result: Maintain

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

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

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

First Identified: Septemer 2011

2019 est Medicare Utilization: 2,111,275

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

RUC Recommendation: 0.32 (Interim)

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

RUC Recommendation: 1.10 **Referred to CPT** May 2018 **Result:** Decrease

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

11981 **Insertion, drug-delivery implant (ie, bioresorbable, biodegradable, non-biodegradable)**

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

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

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

RUC Recommendation: 1.30 **Referred to CPT** May 2018 **Result:** Decrease

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

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

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

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

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

RUC Recommendation: 1.70 **Referred to CPT** May 2018 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

RUC Recommendation: 2.52 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

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

RUC Recommendation: 2.97 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

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

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

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

RUC Recommendation: 3.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Status Report: CMS Requests and Relativity Assessment Issues

12042 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.6 cm to 7.5 cm**

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

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

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

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

12044 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 7.6 cm to 12.5 cm**

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

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

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

RUC Recommendation: 3.19 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

12045 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 12.6 cm to 20.0 cm**

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

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 337

2021 Work RVU: 3.75
2021 NF PE RVU: 7.69
2021 Fac PE RVU: 3.48

RUC Recommendation: 3.90 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12046 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 20.1 cm to 30.0 cm**

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

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 89

2021 Work RVU: 4.30
2021 NF PE RVU: 9.67
2021 Fac PE RVU: 3.99

RUC Recommendation: 4.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12047 **Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; over 30.0 cm**

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

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 50

2021 Work RVU: 4.95
2021 NF PE RVU: 10.26
2021 Fac PE RVU: 4.23

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12051 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less**

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

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 54,376

2021 Work RVU: 2.33
2021 NF PE RVU: 5.76
2021 Fac PE RVU: 2.29

RUC Recommendation: 2.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

12052 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm**

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

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 75,683

2021 Work RVU: 2.87
2021 NF PE RVU: 6.10
2021 Fac PE RVU: 2.58

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

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

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

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,218

2021 Work RVU: 3.17
2021 NF PE RVU: 7.28
2021 Fac PE RVU: 2.66

RUC Recommendation: 3.17 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

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

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

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,576

2021 Work RVU: 3.50
2021 NF PE RVU: 7.45
2021 Fac PE RVU: 2.32

RUC Recommendation: 3.50 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

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Status Report: CMS Requests and Relativity Assessment Issues

12055 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm**

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

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 281

2021 Work RVU: 4.50
2021 NF PE RVU: 9.72
2021 Fac PE RVU: 3.43

RUC Recommendation: 4.65 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12056 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 20.1 cm to 30.0 cm**

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

Most Recent RUC Meeting: October 2010 **Tab:** 22 **Specialty Developing Recommendation:** AAO-HNS, AAD, AAP, ACEP, ASPS, AAFP, ACS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 41

2021 Work RVU: 5.30
2021 NF PE RVU: 11.05
2021 Fac PE RVU: 5.03

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

12057 **Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; over 30.0 cm**

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

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

2021 Work RVU: 6.00
2021 NF PE RVU: 11.25
2021 Fac PE RVU: 5.28

RUC Recommendation: 6.28 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

13100 **Repair, complex, trunk; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 6,433

2021 Work RVU: 3.00
2021 NF PE RVU: 6.88
2021 Fac PE RVU: 2.49

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

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

13101 **Repair, complex, trunk; 2.6 cm to 7.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 102,897

2021 Work RVU: 3.50
2021 NF PE RVU: 8.05
2021 Fac PE RVU: 3.38

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

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

13102 **Repair, complex, trunk; each additional 5 cm or less (list separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 26,791

2021 Work RVU: 1.24
2021 NF PE RVU: 2.09
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain

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

13120 **Repair, complex, scalp, arms, and/or legs; 1.1 cm to 2.5 cm** **Global:** 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 12,693

2021 Work RVU: 3.23
2021 NF PE RVU: 7.04
2021 Fac PE RVU: 3.22

RUC Recommendation: 3.23 **Referred to CPT** September 2018 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

Status Report: CMS Requests and Relativity Assessment Issues

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

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 207,941

2021 Work RVU: 4.00
2021 NF PE RVU: 8.34
2021 Fac PE RVU: 3.08

RUC Recommendation: 4.00 **Referred to CPT** September 2018 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

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

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** October 2008 **2019 est Medicare Utilization:** 31,342

2021 Work RVU: 1.44
2021 NF PE RVU: 2.18
2021 Fac PE RVU: 0.78

RUC Recommendation: 1.44 **Referred to CPT** September 2018 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** 1st article: May 2011; 2nd article July 2016; Sept 2018 CPT Editorial Meeting Tab 9, specialties submitted revisions to the guidelines.

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

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

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 41,454

2021 Work RVU: 3.73
2021 NF PE RVU: 7.46
2021 Fac PE RVU: 2.90

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

13132 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 309,273

2021 Work RVU: 4.78
2021 NF PE RVU: 8.81
2021 Fac PE RVU: 3.52

RUC Recommendation: 4.78 **Referred to CPT** **Result:** Decrease

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

13133 **Repair, complex, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; each additional 5 cm or less (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 17,262

2021 Work RVU: 2.19
2021 NF PE RVU: 2.58
2021 Fac PE RVU: 1.22

RUC Recommendation: 2.19 **Referred to CPT** **Result:** Maintain

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

13150 **Repair, complex, eyelids, nose, ears and/or lips; 1.0 cm or less**

Global: **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

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

13151 **Repair, complex, eyelids, nose, ears and/or lips; 1.1 cm to 2.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** September 2011 **2019 est Medicare Utilization:** 33,842

2021 Work RVU: 4.34
2021 NF PE RVU: 7.79
2021 Fac PE RVU: 3.26

RUC Recommendation: 4.34 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

13152 **Repair, complex, eyelids, nose, ears and/or lips; 2.6 cm to 7.5 cm**

Global: 010 **Issue:** Complex Wound Repair **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued with Annual Allowed Charges over $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 54,926

2021 Work RVU: 5.34
2021 NF PE RVU: 8.93
2021 Fac PE RVU: 3.83

RUC Recommendation: 5.34 **Referred to CPT** **Result:** Decrease

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

13153 **Repair, complex, eyelids, nose, ears and/or lips; each additional 5 cm or less (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Complex Wound Repair **Screen:** CMS Request **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 37 **Specialty Developing Recommendation:** AAD, AAO-HNS, ASPS **First Identified:** July 2011 **2019 est Medicare Utilization:** 938

2021 Work RVU: 2.38
2021 NF PE RVU: 2.80
2021 Fac PE RVU: 1.28

RUC Recommendation: 2.38 **Referred to CPT** **Result:** Maintain

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

14000 **Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** April 2008 **2019 est Medicare Utilization:** 7,303

2021 Work RVU: 6.37
2021 NF PE RVU: 11.17
2021 Fac PE RVU: 7.16

RUC Recommendation: 6.19 **Referred to CPT** **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

14001 **Adjacent tissue transfer or rearrangement, trunk; defect 10.1 sq cm to 30.0 sq cm** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** ACS, AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,637

2021 Work RVU: 8.78
2021 NF PE RVU: 13.39
2021 Fac PE RVU: 8.68

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14020 **Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** April 2008 **2019 est Medicare Utilization:** 17,817

2021 Work RVU: 7.22
2021 NF PE RVU: 12.29
2021 Fac PE RVU: 8.16

RUC Recommendation: 7.02 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14021 **Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 19,350

2021 Work RVU: 9.72
2021 NF PE RVU: 14.29
2021 Fac PE RVU: 9.54

RUC Recommendation: 9.52 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14040 **Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less** **Global:** 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 67,406

2021 Work RVU: 8.60
2021 NF PE RVU: 12.51
2021 Fac PE RVU: 8.42

RUC Recommendation: 8.44 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14041 **Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 45,011

2021 Work RVU: 10.83
2021 NF PE RVU: 14.84
2021 Fac PE RVU: 9.98

RUC Recommendation: 10.63 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14060 **Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 90,113

2021 Work RVU: 9.23
2021 NF PE RVU: 12.12
2021 Fac PE RVU: 8.93

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

14061 **Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10.1 sq cm to 30.0 sq cm**

Global: 090 **Issue:** Skin Tissue Rearrangement **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 9 **Specialty Developing Recommendation:** AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 31,224

2021 Work RVU: 11.48
2021 NF PE RVU: 16.18
2021 Fac PE RVU: 10.86

RUC Recommendation: 11.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

14300 **Deleted from CPT**

Global: **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACS, AAD, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

14301 **Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm**

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

Most Recent RUC Meeting: April 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 38,864

2021 Work RVU: 12.65
2021 NF PE RVU: 17.28
2021 Fac PE RVU: 10.74

RUC Recommendation: 12.47 **Referred to CPT** February 2009 **Result:** Decrease

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

14302 **Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Adjacent Tissue Transfer **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACS, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 40,086

2021 Work RVU: 3.73
2021 NF PE RVU: 1.96
2021 Fac PE RVU: 1.96

RUC Recommendation: 3.73 **Referred to CPT** February 2009 **Result:** Decrease

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

15002 **Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children**

Global: 000 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2014 **2019 est Medicare Utilization:** 24,066

2021 Work RVU: 3.65
2021 NF PE RVU: 6.16
2021 Fac PE RVU: 2.17

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** **Result:** Maintain

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

Status Report: CMS Requests and Relativity Assessment Issues

15004 **Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children**

Global: 000 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 32,464

2021 Work RVU: 4.58
2021 NF PE RVU: 6.61
2021 Fac PE RVU: 2.44

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

Result: Maintain

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

15100 **Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2014 **2019 est Medicare Utilization:** 13,549

2021 Work RVU: 9.90
2021 NF PE RVU: 13.91
2021 Fac PE RVU: 9.16

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

Result: Maintain

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

15120 **Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)**

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

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,650

2021 Work RVU: 10.15
2021 NF PE RVU: 13.24
2021 Fac PE RVU: 8.42

RUC Recommendation: Remove from screen

Referred to CPT

Result: Remove from Screen

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

Status Report: CMS Requests and Relativity Assessment Issues

15170 **Acellular dermal replacement, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

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

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

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

15171 **Acellular dermal replacement, trunk, arms, legs; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

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

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

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

15175 **Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

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

Status Report: CMS Requests and Relativity Assessment Issues

15176 **Acellular dermal replacement, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)**

Global: **Issue:** Acellular Dermal Replacement **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT

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

Result: Deleted from CPT

15220 **Full thickness graft, free, including direct closure of donor site, scalp, arms, and/or legs; 20 sq cm or less**

Global: 090 **Issue:** Skin Graft **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,947

2021 Work RVU: 8.09
2021 NF PE RVU: 13.42
2021 Fac PE RVU: 8.53

RUC Recommendation: Reduce 99238 to 0.5

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

Result: PE Only

15240 **Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ASPS, AAD **First Identified:** January 2014 **2019 est Medicare Utilization:** 13,328

2021 Work RVU: 10.41
2021 NF PE RVU: 15.47
2021 Fac PE RVU: 11.30

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

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

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

15271 **Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 111,779

2021 Work RVU: 1.50
2021 NF PE RVU: 2.83
2021 Fac PE RVU: 0.73

RUC Recommendation: 1.50 **Referred to CPT** February 2011 **Result:** Decrease

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

15272 **Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 14,569

2021 Work RVU: 0.33
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.12

RUC Recommendation: 0.59 **Referred to CPT** February 2011 **Result:** Decrease

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

15273 **Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,775

2021 Work RVU: 3.50
2021 NF PE RVU: 5.22
2021 Fac PE RVU: 1.67

RUC Recommendation: 3.50 **Referred to CPT** February 2011 **Result:** Decrease

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

Status Report: CMS Requests and Relativity Assessment Issues

15274 **Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 25,402

2021 Work RVU: 0.80
2021 NF PE RVU: 1.48
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.80 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15275 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 122,551

2021 Work RVU: 1.83
2021 NF PE RVU: 2.68
2021 Fac PE RVU: 0.72

RUC Recommendation: 1.83 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15276 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 6,340

2021 Work RVU: 0.50
2021 NF PE RVU: 0.40
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.59 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15277 **Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children**

Global: 000 **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,720

2021 Work RVU: 4.00
2021 NF PE RVU: 5.53
2021 Fac PE RVU: 1.89

RUC Recommendation: 4.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 2,936

2021 Work RVU: 1.00
2021 NF PE RVU: 1.65
2021 Fac PE RVU: 0.46

RUC Recommendation: 1.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

15320 **Deleted from CPT**

Global: **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15321 **Deleted from CPT**

Global: **Issue:** Skin Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

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

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

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

15330 **Acellular dermal allograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children**

Global: **Issue:** Allograft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASPS **First Identified:** February 2008 **2019 est Medicare Utilization:**

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

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

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

15331 **Deleted from CPT**

Global: **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

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

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

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

15335 **Deleted from CPT**

Global: **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:**

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

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15336 **Deleted from CPT** **Global:** **Issue:** Acellular Dermal Allograft **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAO-HNS, APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15360 **Deleted from CPT** **Global:** **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15361 **Deleted from CPT** **Global:** **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15365 **Deleted from CPT** **Global:** **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15366 **Deleted from CPT**

Global: **Issue:** Tissue Cultured Allogeneic Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15400 **Deleted from CPT**

Global: **Issue:** Xenograft **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15401 **Deleted from CPT**

Global: **Issue:** Xenograft **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACS, ASPS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15420 **Deleted from CPT**

Global: **Issue:** Xenograft Skin **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS, AAD **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15421 **Deleted from CPT** **Global:** **Issue:** Xenograft Skin **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** APMA, ASPS, AAD **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

15570 **Formation of direct or tubed pedicle, with or without transfer; trunk** **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 292

2021 Work RVU: 10.21
2021 NF PE RVU: 14.85
2021 Fac PE RVU: 9.36

RUC Recommendation: 10.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

15572 **Formation of direct or tubed pedicle, with or without transfer; scalp, arms, or legs** **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ACS, ASPS, AAO-HNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 691

2021 Work RVU: 10.12
2021 NF PE RVU: 14.00
2021 Fac PE RVU: 9.64

RUC Recommendation: 9.94 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

15574 **Formation of direct or tubed pedicle, with or without transfer; forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands or feet** **Global:** 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,483

2021 Work RVU: 10.70
2021 NF PE RVU: 13.68
2021 Fac PE RVU: 9.34

RUC Recommendation: 10.52 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15576 **Formation of direct or tubed pedicle, with or without transfer; eyelids, nose, ears, lips, or intraoral**

Global: 090 **Issue:** Skin Pedicle Flaps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 10 **Specialty Developing Recommendation:** ASPS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,346

2021 Work RVU: 9.37
2021 NF PE RVU: 12.76
2021 Fac PE RVU: 8.61

RUC Recommendation: 9.24 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15730 **Midface flap (ie, zygomaticofacial flap) with preservation of vascular pedicle(s)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** AAO **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,767

2021 Work RVU: 13.50
2021 NF PE RVU: 28.61
2021 Fac PE RVU: 11.48

RUC Recommendation: 13.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15731 **Forehead flap with preservation of vascular pedicle (eg, axial pattern flap, paramedian forehead flap)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,362

2021 Work RVU: 14.38
2021 NF PE RVU: 16.41
2021 Fac PE RVU: 12.59

RUC Recommendation: Not part of family **Referred to CPT** September 2016 **Result:** Not Part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15732 **Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)**

Global: **Issue:** Muscle Flaps **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

15733 **Muscle, myocutaneous, or fasciocutaneous flap; head and neck with named vascular pedicle (ie, buccinators, genioglossus, temporalis, masseter, sternocleidomastoid, levator scapulae)**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 05 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2017 **2019 est Medicare Utilization:** 5,657

2021 Work RVU: 15.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.20

RUC Recommendation: 15.68 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15734 **Muscle, myocutaneous, or fasciocutaneous flap; trunk**

Global: 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 14 **Specialty Developing Recommendation:** **First Identified:** October 2015 **2019 est Medicare Utilization:** 24,232

2021 Work RVU: 23.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.46

RUC Recommendation: 23.00 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15736 **Muscle, myocutaneous, or fasciocutaneous flap; upper extremity** **Global:** 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 14 **Specialty Developing Recommendation:** ASSH, ASPS **First Identified:** January 2016 **2019 est Medicare Utilization:** 1,501

2021 Work RVU: 17.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.54

RUC Recommendation: 17.04 **Referred to CPT** September 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15738 **Muscle, myocutaneous, or fasciocutaneous flap; lower extremity** **Global:** 090 **Issue:** Muscle Flaps **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 14 **Specialty Developing Recommendation:** ASPS **First Identified:** January 2016 **2019 est Medicare Utilization:** 6,218

2021 Work RVU: 19.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.12

RUC Recommendation: 19.04 **Referred to CPT** September 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

15740 **Flap; island pedicle requiring identification and dissection of an anatomically named axial vessel** **Global:** 090 **Issue:** Dermatology and Plastic Surgery Procedures **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 28 **Specialty Developing Recommendation:** AAD, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,046

2021 Work RVU: 11.80
2021 NF PE RVU: 15.93
2021 Fac PE RVU: 10.87

RUC Recommendation: 11.57 **Referred to CPT** February 2009 & February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15769 **Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)** **Global:** 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** AAOHNS, ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.24

RUC Recommendation: 6.68. Flagged for RAW review April 2022. **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15771 **Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate** **Global:** 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.73
2021 NF PE RVU: 8.97
2021 Fac PE RVU: 6.08

RUC Recommendation: 6.73 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15772 **Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (list separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.50
2021 NF PE RVU: 2.34
2021 Fac PE RVU: 1.15

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

15773 **Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate**

Global: 090 **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.83
2021 NF PE RVU: 9.01
2021 Fac PE RVU: 6.12

RUC Recommendation: 6.83 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15774 **Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Tissue Grafting Procedures **Screen:** Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** ASPS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.41
2021 NF PE RVU: 2.30
2021 Fac PE RVU: 1.11

RUC Recommendation: 2.41 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

15777 **Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chronic Wound Dermal Substitute **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACS, APMA, ASPS **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,429

2021 Work RVU: 3.65
2021 NF PE RVU: 1.97
2021 Fac PE RVU: 1.97

RUC Recommendation: 3.65 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

157X1

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 8.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

15823 **Blepharoplasty, upper eyelid; with excessive skin weighting down lid**

Global: 090 **Issue:** Upper Eyelid Blepharoplasty **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 33 **Specialty Developing Recommendation:** AAO **First Identified:** October 2009 **2019 est Medicare Utilization:** 97,994

2021 Work RVU: 6.81
2021 NF PE RVU: 10.71
2021 Fac PE RVU: 8.60

RUC Recommendation: 6.81 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

16020 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 08 **Specialty Developing Recommendation:** ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 15,272

2021 Work RVU: 0.71
2021 NF PE RVU: 1.66
2021 Fac PE RVU: 0.77

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

16025 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; medium (eg, whole face or whole extremity, or 5% to 10% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 08 **Specialty Developing Recommendation:** ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 1,908

2021 Work RVU: 1.74
2021 NF PE RVU: 2.58
2021 Fac PE RVU: 1.22

RUC Recommendation: 1.85 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

16030 **Dressings and/or debridement of partial-thickness burns, initial or subsequent; large (eg, more than 1 extremity, or greater than 10% total body surface area)**

Global: 000 **Issue:** Dressings/ Debridement of Partial-Thickness Burns **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACEP, ASPS, AAFP, AAPMR, ACS, AAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 879

2021 Work RVU: 2.08
2021 NF PE RVU: 3.28
2021 Fac PE RVU: 1.38

RUC Recommendation: CPT Assistant article published. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2012

17000 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion**

Global: 010 **Issue:** Destruction of Premalignant Lesions **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:** 6,117,793

2021 Work RVU: 0.61
2021 NF PE RVU: 1.27
2021 Fac PE RVU: 0.90

RUC Recommendation: 0.61 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17003 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); second through 14 lesions, each (list separately in addition to code for first lesion)**

Global: ZZZ **Issue:** Destruction of Premalignant Lesions **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2010 **2019 est Medicare Utilization:** 19,474,499

2021 Work RVU: 0.04
2021 NF PE RVU: 0.15
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.04 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

17004 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions**

Global: 010 **Issue:** Destruction of Premalignant Lesions **Screen:** CMS High Expenditure Procedural Codes1 / Modifer -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 874,685

2021 Work RVU: 1.37
2021 NF PE RVU: 3.35
2021 Fac PE RVU: 1.34

RUC Recommendation: Remove from Modifier -51 Exempt List. 1.37 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

17106 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,933

2021 Work RVU: 3.69
2021 NF PE RVU: 5.92
2021 Fac PE RVU: 3.87

RUC Recommendation: 3.61 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17107 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,449

2021 Work RVU: 4.79
2021 NF PE RVU: 7.74
2021 Fac PE RVU: 5.00

RUC Recommendation: 4.68 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17108 **Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm**

Global: 090 **Issue:** Destruction of Skin Lesions **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 11 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,081

2021 Work RVU: 7.49
2021 NF PE RVU: 10.10
2021 Fac PE RVU: 6.78

RUC Recommendation: 6.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

17110 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions**

Global: 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,556,286

2021 Work RVU: 0.70
2021 NF PE RVU: 2.57
2021 Fac PE RVU: 1.15

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17111 **Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions**

Global: 010 **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 122,909

2021 Work RVU: 0.97
2021 NF PE RVU: 2.84
2021 Fac PE RVU: 1.29

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

17250 **Chemical cauterization of granulation tissue (ie, proud flesh)**

Global: 000 **Issue:** RAW **Screen:** High Volume Growth3 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAFP, ACS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 234,080

2021 Work RVU: 0.50
2021 NF PE RVU: 2.07
2021 Fac PE RVU: 0.50

RUC Recommendation: Review in 2 years (Jan 2022). **Referred to CPT** September 2016 **Result:**

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

17261 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 140,325

2021 Work RVU: 1.22
2021 NF PE RVU: 3.00
2021 Fac PE RVU: 1.17

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17262 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), trunk, arms or legs; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 287,333

2021 Work RVU: 1.63
2021 NF PE RVU: 3.45
2021 Fac PE RVU: 1.40

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17271 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 53,690

2021 Work RVU: 1.54
2021 NF PE RVU: 3.18
2021 Fac PE RVU: 1.35

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17272 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 82,281

2021 Work RVU: 1.82
2021 NF PE RVU: 3.54
2021 Fac PE RVU: 1.51

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17281 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.6 to 1.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** February 2010 **2019 est Medicare Utilization:** 86,818

2021 Work RVU: 1.77
2021 NF PE RVU: 3.33
2021 Fac PE RVU: 1.48

RUC Recommendation: 1.77 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17282 **Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 1.1 to 2.0 cm**

Global: 010 **Issue:** Destruction of Malignant Lesion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 26 **Specialty Developing Recommendation:** AAD, AAFP **First Identified:** October 2009 **2019 est Medicare Utilization:** 81,831

2021 Work RVU: 2.09
2021 NF PE RVU: 3.74
2021 Fac PE RVU: 1.66

RUC Recommendation: 2.09 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17311 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; first stage, up to 5 tissue blocks**

Global: 000 **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 829,586

2021 Work RVU: 6.20
2021 NF PE RVU: 12.99
2021 Fac PE RVU: 3.57

RUC Recommendation: 6.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17312 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), head, neck, hands, feet, genitalia, or any location with surgery directly involving muscle, cartilage, bone, tendon, major nerves, or vessels; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** September 2011 **2019 est Medicare Utilization:** 509,267

2021 Work RVU: 3.30
2021 NF PE RVU: 8.41
2021 Fac PE RVU: 1.89

RUC Recommendation: 3.30 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17313 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks**

Global: 000 **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 140,796

2021 Work RVU: 5.56
2021 NF PE RVU: 12.49
2021 Fac PE RVU: 3.20

RUC Recommendation: 5.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

17314 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; each additional stage after the first stage, up to 5 tissue blocks (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 57,990

2021 Work RVU: 3.06
2021 NF PE RVU: 8.16
2021 Fac PE RVU: 1.76

RUC Recommendation: 3.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

17315 **Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), each additional block after the first 5 tissue blocks, any stage (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Mohs Surgery **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAD **First Identified:** January 2012 **2019 est Medicare Utilization:** 19,946

2021 Work RVU: 0.87
2021 NF PE RVU: 1.30
2021 Fac PE RVU: 0.50

RUC Recommendation: 0.87 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

19020 **Mastotomy with exploration or drainage of abscess, deep**

Global: 090 **Issue:** Mastotomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,614

2021 Work RVU: 3.83
2021 NF PE RVU: 9.57
2021 Fac PE RVU: 4.50

RUC Recommendation: Reduce 99238 to 0.5, remove hospital visits **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

19081 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 60,561

2021 Work RVU: 3.29
2021 NF PE RVU: 13.26
2021 Fac PE RVU: 1.19

RUC Recommendation: 3.29 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19082 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including stereotactic guidance (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 4,476

2021 Work RVU: 1.65
2021 NF PE RVU: 11.70
2021 Fac PE RVU: 0.60

RUC Recommendation: 1.65 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19083 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 118,588

2021 Work RVU: 3.10
2021 NF PE RVU: 13.47
2021 Fac PE RVU: 1.12

RUC Recommendation: 3.10 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19084 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 15,269

2021 Work RVU: 1.55
2021 NF PE RVU: 11.57
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.55 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19085 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 5,634

2021 Work RVU: 3.64
2021 NF PE RVU: 22.01
2021 Fac PE RVU: 1.32

RUC Recommendation: 3.64 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19086 **Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,195

2021 Work RVU: 1.82
2021 NF PE RVU: 18.59
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.82 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19102 **Biopsy of breast; percutaneous, needle core, using imaging guidance**

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19103 **Biopsy of breast; percutaneous, automated vacuum assisted or rotating biopsy device, using imaging guidance**

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

19281 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including mammographic guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 30,514

2021 Work RVU: 2.00
2021 NF PE RVU: 5.08
2021 Fac PE RVU: 0.72

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

19282 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including mammographic guidance (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 3,292

2021 Work RVU: 1.00
2021 NF PE RVU: 4.08
2021 Fac PE RVU: 0.36

RUC Recommendation: 1.00 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19283 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including stereotactic guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 3,526

2021 Work RVU: 2.00
2021 NF PE RVU: 5.80
2021 Fac PE RVU: 0.72

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19284 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including stereotactic guidance (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 338

2021 Work RVU: 1.00
2021 NF PE RVU: 4.98
2021 Fac PE RVU: 0.36

RUC Recommendation: 1.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19285 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 25,714

2021 Work RVU: 1.70
2021 NF PE RVU: 10.83
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.70 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19286 **Placement of breast localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including ultrasound guidance (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 2,002

2021 Work RVU: 0.85
2021 NF PE RVU: 9.77
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.85 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19287 **Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance**

Global: 000 **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 266

2021 Work RVU: 2.55
2021 NF PE RVU: 19.02
2021 Fac PE RVU: 0.92

RUC Recommendation: 3.02 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19288 **Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:** 60

2021 Work RVU: 1.28
2021 NF PE RVU: 15.82
2021 Fac PE RVU: 0.46

RUC Recommendation: 1.51 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19290 **Preoperative placement of needle localization wire, breast;**

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

19291 **Preoperative placement of needle localization wire, breast; each additional lesion (List separately in addition to code for primary procedure)**

Global: **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

19295 **Image guided placement, metallic localization clip, percutaneous, during breast biopsy/aspiration (List separately in addition to code for primary procedure)**

Global: **Issue:** Breast Biopsy **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, ACS, ASBS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19303 **Mastectomy, simple, complete**

Global: 090 **Issue:** Mastectomy **Screen:** Site of Service Anomaly - 2015 / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACS, ASBS **First Identified:** October 2015 **2019 est Medicare Utilization:** 24,587

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.73

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19307 **Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle**

Global: 090 **Issue:** Modified Radical Mastectomy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 22 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 6,042

2021 Work RVU: 17.99
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.69

RUC Recommendation: 17.99 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19318 **Breast reduction**

Global: 090 **Issue:** Mammaplasty **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,501

2021 Work RVU: 16.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.22

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

19340 **Insertion of breast implant on same day of mastectomy (ie, immediate)**

Global: 090 **Issue:** Breast Implant/Expander Placement **Screen:** CMS Request / Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 05 **Specialty Developing Recommendation:** ASPS **First Identified:** October 2009 **2019 est Medicare Utilization:** 7,433

2021 Work RVU: 10.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.81

RUC Recommendation: 11.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

19357 **Tissue expander placement in breast reconstruction, including subsequent expansion(s)**

Global: 090 **Issue:** Breast Implant/Expander Placement **Screen:** Site of Service Anomaly / 090-Day Global Post-Operative Visits / Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 05 **Specialty Developing Recommendation:** ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 6,479

2021 Work RVU: 14.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.67

RUC Recommendation: 15.36 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

20000 **Deleted from CPT**

Global: **Issue:** Incision of Abcess **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20005 **Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)**

Global: **Issue:** Incision of Deep Abscess **Screen:** Site of Service Anomaly / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

20220 **Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)**

Global: 000 **Issue:** Bone Biopsy Trocar/Needle **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 22 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2018 **2019 est Medicare Utilization:** 12,355

2021 Work RVU: 1.65
2021 NF PE RVU: 5.58
2021 Fac PE RVU: 0.75

RUC Recommendation: 1.93 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

20225 **Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)**

Global: 000 **Issue:** Bone Biopsy Trocar/Needle **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 22 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 14,341

2021 Work RVU: 2.45
2021 NF PE RVU: 9.49
2021 Fac PE RVU: 1.11

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

20240 **Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)**

Global: 000 **Issue:** Bone Biopsy Excisional **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 04 **Specialty Developing Recommendation:** AAOS, APMA **First Identified:** April 2014 **2019 est Medicare Utilization:** 6,533

2021 Work RVU: 2.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.25

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20245 **Biopsy, bone, open; deep (eg, humeral shaft, ischium, femoral shaft)** **Global:** 000 **Issue:** Bone Biopsy Excisional **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 04 **Specialty Developing Recommendation:** AAOS **First Identified:** January 2014 **2019 est Medicare Utilization:** 4,354

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.17

RUC Recommendation: 6.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

20525 **Removal of foreign body in muscle or tendon sheath; deep or complicated** **Global:** 010 **Issue:** Removal of Foreign Body **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,693

2021 Work RVU: 3.54
2021 NF PE RVU: 10.08
2021 Fac PE RVU: 3.09

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

20526 **Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel** **Global:** 000 **Issue:** RAW **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** July 2016 **2019 est Medicare Utilization:** 102,673

2021 Work RVU: 0.94
2021 NF PE RVU: 1.27
2021 Fac PE RVU: 0.57

RUC Recommendation: Remove fromm screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20550 **Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")**

Global: 000 **Issue:** Injection of Tendon **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, AAPM&R, ACRh, APMA, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 848,059

2021 Work RVU: 0.75
2021 NF PE RVU: 0.80
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20551 **Injection(s); single tendon origin/insertion**

Global: 000 **Issue:** Therapeutic Injection Carpal Tunnel **Screen:** CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 10 **Specialty Developing Recommendation:** AAPMR, AAOS, ACRh, APMA, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 163,234

2021 Work RVU: 0.75
2021 NF PE RVU: 0.84
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20552 **Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)**

Global: 000 **Issue:** **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 28 **Specialty Developing Recommendation:** AAPM&R, ACRh, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 350,677

2021 Work RVU: 0.66
2021 NF PE RVU: 0.84
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.66 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20553 **Injection(s); single or multiple trigger point(s), 3 or more muscles**

Global: 000 **Issue:** **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 28 **Specialty Developing Recommendation:** AAPM&R, ACRh, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 378,100

2021 Work RVU: 0.75
2021 NF PE RVU: 0.98
2021 Fac PE RVU: 0.41

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20600 **Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** February 2010 **2019 est Medicare Utilization:** 444,325

2021 Work RVU: 0.66
2021 NF PE RVU: 0.77
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.66 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

20604 **Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 46,354

2021 Work RVU: 0.89
2021 NF PE RVU: 1.38
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.89 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20605 **Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** October 2009 **2019 est Medicare Utilization:** 466,622

2021 Work RVU: 0.68
2021 NF PE RVU: 0.81
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.68 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

20606 **Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 56,334

2021 Work RVU: 1.00
2021 NF PE RVU: 1.47
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.00 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20610 **Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance**

Global: 000 **Issue:** Arthrocentesis **Screen:** Harvard Valued - Utilization over 100,000 / MPC List / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,722,382

2021 Work RVU: 0.79
2021 NF PE RVU: 0.96
2021 Fac PE RVU: 0.42

RUC Recommendation: 0.79 and new PE inputs **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20611 **Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting**

Global: 000 **Issue:** Arthrocentesis **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 04 **Specialty Developing Recommendation:** AAFP, AAOS, ACR, ACRh, APMA, ASSH **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,069,935

2021 Work RVU: 1.10
2021 NF PE RVU: 1.65
2021 Fac PE RVU: 0.51

RUC Recommendation: 1.10 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20612 **Aspiration and/or injection of ganglion cyst(s) any location**

Global: 000 **Issue:** RAW **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** July 2016 **2019 est Medicare Utilization:** 28,400

2021 Work RVU: 0.70
2021 NF PE RVU: 1.06
2021 Fac PE RVU: 0.41

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

20680 **Removal of implant; deep (eg, buried wire, pin, screw, metal band, nail, rod or plate)**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 55,761

2021 Work RVU: 5.96
2021 NF PE RVU: 11.22
2021 Fac PE RVU: 5.36

RUC Recommendation: 5.96 and adjustments to pre-service time package 3. **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20692 **Application of a multiplane (pins or wires in more than 1 plane), unilateral, external fixation system (eg, ilizarov, monticelli type)**

Global: 090 **Issue:** RAW **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:**

First Identified: January 2014 **2019 est Medicare Utilization:** 3,150

2021 Work RVU: 16.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.87

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

20694 **Removal, under anesthesia, of external fixation system**

Global: 090 **Issue:** External Fixation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS

First Identified: September 2007 **2019 est Medicare Utilization:** 6,209

2021 Work RVU: 4.28
2021 NF PE RVU: 7.72
2021 Fac PE RVU: 4.95

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

20700 **Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA

First Identified: May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.50
2021 NF PE RVU: 0.68
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

20701 **Removal of drug-delivery device(s), deep (eg, subfascial) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA

First Identified: May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.13
2021 NF PE RVU: 0.51
2021 Fac PE RVU: 0.51

RUC Recommendation: 1.13

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

20702 **Manual preparation and insertion of drug-delivery device(s), intramedullary (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.50
2021 NF PE RVU: 1.14
2021 Fac PE RVU: 1.14

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20703 **Removal of drug-delivery device(s), intramedullary (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.80
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.82

RUC Recommendation: 1.80 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20704 **Manual preparation and insertion of drug-delivery device(s), intra-articular (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.60
2021 NF PE RVU: 1.19
2021 Fac PE RVU: 1.19

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

20705 **Removal of drug-delivery device(s), intra-articular (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Drug Delivery Implant Procedures **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAOS, AUA **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.15
2021 NF PE RVU: 0.98
2021 Fac PE RVU: 0.98

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

20900 **Bone graft, any donor area; minor or small (eg, dowel or button)** **Global:** 000 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,436

2021 Work RVU: 3.00
2021 NF PE RVU: 8.60
2021 Fac PE RVU: 1.85

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20902 **Bone graft, any donor area; major or large** **Global:** 000 **Issue:** Bone Graft Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 29 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** April 2008 **2019 est Medicare Utilization:** 4,599

2021 Work RVU: 4.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.76

RUC Recommendation: 4.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

20926 **Tissue grafts, other (eg, paratenon, fat, dermis)** **Global:** **Issue:** Tissue Grafting Procedures **Screen:** CMS Fastest Growing / Site of Service Anomaly - 2017 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 04 **Specialty Developing Recommendation:** AAOS, ASPS, AANS, CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 14,815

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted for 2020

21015 **Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm** **Global:** 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS, AAO-HNS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 506

2021 Work RVU: 9.89
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.04

RUC Recommendation: 9.71 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21025 **Excision of bone (eg, for osteomyelitis or bone abscess); mandible**

Global: 090 **Issue:** Excision of Bone – Mandible **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 61 **Specialty Developing Recommendation:** AAOMS

First Identified: September 2007 **2019 est Medicare Utilization:** 3,614

2021 Work RVU: 10.03
2021 NF PE RVU: 12.52
2021 Fac PE RVU: 8.55

RUC Recommendation: 10.03

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

21495 **Open treatment of hyoid fracture**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:**

First Identified: October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

21557 **Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS

First Identified: September 2007 **2019 est Medicare Utilization:** 490

2021 Work RVU: 14.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.39

RUC Recommendation: 14.57

Referred to CPT June 2008
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

21800 **Closed treatment of rib fracture, uncomplicated, each**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS

First Identified: July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

21805 **Open treatment of rib fracture without fixation, each**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

21810 **Treatment of rib fracture requiring external fixation (flail chest)**

Global: **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

21811 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs**

Global: 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 357

2021 Work RVU: 10.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.31

RUC Recommendation: 19.55 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

21812 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs**

Global: 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 468

2021 Work RVU: 13.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.32

RUC Recommendation: 25.00 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21813 **Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs**

Global: 000 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 62

2021 Work RVU: 17.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.08

RUC Recommendation: 35.00 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

21820 **Closed treatment of sternum fracture**

Global: 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 / Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** January 2014 **2019 est Medicare Utilization:** 190

2021 Work RVU: 1.36
2021 NF PE RVU: 2.76
2021 Fac PE RVU: 2.69

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** October 2013 **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

21825 **Open treatment of sternum fracture with or without skeletal fixation**

Global: 090 **Issue:** Internal Fixation of Rib Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 05 **Specialty Developing Recommendation:** STS, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 737

2021 Work RVU: 7.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.59

RUC Recommendation: Unrelated to the family **Referred to CPT** October 2013 **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

21935 **Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm**

Global: 090 **Issue:** Radical Resection of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 235

2021 Work RVU: 15.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.11

RUC Recommendation: 15.54 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22214 **Osteotomy of spine, posterior or posterolateral approach, 1 vertebral segment; lumbar**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 6,695

2021 Work RVU: 21.02
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.74

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

22305 **Closed treatment of vertebral process fracture(s)**

Global: **Issue:** Closed treatment of vertebral process fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 23 **Specialty Developing Recommendation:** AANS/CNS, NASS **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22310 **Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing**

Global: 090 **Issue:** Closed Treatment Vertebral Fracture **Screen:** Negative IWPUT / Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 23 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** April 2017 **2019 est Medicare Utilization:** 6,942

2021 Work RVU: 3.45
2021 NF PE RVU: 4.93
2021 Fac PE RVU: 4.53

RUC Recommendation: 3.45. Flag for Rereview **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22510 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; cervicothoracic**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 3,686

2021 Work RVU: 7.90
2021 NF PE RVU: 47.52
2021 Fac PE RVU: 3.71

RUC Recommendation: 8.15 **Referred to CPT** February 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22511 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; lumbosacral**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 4,104

2021 Work RVU: 7.33
2021 NF PE RVU: 47.95
2021 Fac PE RVU: 3.58

RUC Recommendation: 8.05 **Referred to CPT** February 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22512 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection, inclusive of all imaging guidance; each additional cervicothoracic or lumbosacral vertebral body (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 2,505

2021 Work RVU: 4.00
2021 NF PE RVU: 19.83
2021 Fac PE RVU: 1.42

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22513 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; thoracic**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 24,396

2021 Work RVU: 8.65
2021 NF PE RVU: 185.14
2021 Fac PE RVU: 4.81

RUC Recommendation: 8.90 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22514 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; lumbar**

Global: 010 **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 26,776

2021 Work RVU: 7.99
2021 NF PE RVU: 185.16
2021 Fac PE RVU: 4.57

RUC Recommendation: 8.24 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22515 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device (eg, kyphoplasty), 1 vertebral body, unilateral or bilateral cannulation, inclusive of all imaging guidance; each additional thoracic or lumbar vertebral body (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 15,688

2021 Work RVU: 4.00
2021 NF PE RVU: 100.20
2021 Fac PE RVU: 1.68

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22520 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; thoracic**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

22521 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; lumbar**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Site of Service Anomaly (99238-Only); CMS Request - PE Inputs / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22522 **Percutaneous vertebroplasty (bone biopsy included when performed), 1 vertebral body, unilateral or bilateral injection; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22523 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); thoracic**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22524 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); lumbar**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22525 **Percutaneous vertebral augmentation, including cavity creation (fracture reduction and bone biopsy included when performed) using mechanical device, 1 vertebral body, unilateral or bilateral cannulation (eg, kyphoplasty); each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Vertebroplasty and Augementation **Screen:** CMS Request: PE Review **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:** AANS, CNS, AAOS, NASS, ACR, SIR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

22533 **Arthrodesis, lateral extracavitary technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar**

Global: 090 **Issue:** Arthrodesis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 908

2021 Work RVU: 24.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 18.10

RUC Recommendation: Remove from screen. CPT Assistant article published. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

22551 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below c2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 40,145

2021 Work RVU: 25.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.59

RUC Recommendation: 24.50 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22552 **Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below c2, each additional interspace (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 35,696

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.20

RUC Recommendation: 6.50 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

22554 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); cervical below c2**

Global: 090 **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 4,675

2021 Work RVU: 17.69
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.17

RUC Recommendation: 17.69 **Referred to CPT** October 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

22558 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); lumbar**

Global: 090 **Issue:** Vertebral Corpectomy with Arthrodesis **Screen:** High Volume Growth2 / Codes Reported Together 75% or More-Part3 **Complete?** No

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** April 2013 **2019 est Medicare Utilization:** 20,376

2021 Work RVU: 23.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.54

RUC Recommendation: Review action plan and additional data **Referred to CPT** September 2016 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22585 **Arthrodesis, anterior interbody technique, including minimal discectomy to prepare interspace (other than for decompression); each additional interspace (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 05 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 17,132

2021 Work RVU: 5.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.57

RUC Recommendation: Remove from screen **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22612 **Arthrodesis, posterior or posterolateral technique, single interspace; lumbar (with lateral transverse technique, when performed)**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 44,894

2021 Work RVU: 23.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.98

RUC Recommendation: Review utilization data October 2015. 23.53. Maintain work RVU and adjust the times from pre-time package 4. **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22614 **Arthrodesis, posterior or posterolateral technique, single interspace; each additional interspace (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 144,296

2021 Work RVU: 6.43
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.19

RUC Recommendation: 6.43 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22630 **Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,654

2021 Work RVU: 22.09
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.38

RUC Recommendation: 22.09 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

22632 **Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,875

2021 Work RVU: 5.22
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.56

RUC Recommendation: 5.22 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

22633 **Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar**

Global: 090 **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 38,096

2021 Work RVU: 27.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 18.89

RUC Recommendation: 27.75 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22634 **Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Arthrodesis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 04 **Specialty Developing Recommendation:** AANS/CNS, AAOS, NASS **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,338

2021 Work RVU: 8.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.04

RUC Recommendation: 8.16 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22843 **Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Spine Fixation Device **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** AAOS, NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 8,692

2021 Work RVU: 13.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.67

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

22849 **Reinsertion of spinal fixation device**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, NASS, AANS/CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 4,231

2021 Work RVU: 19.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.05

RUC Recommendation: Maintain **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22851 **Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), methylmethacrylate) to vertebral defect or interspace (List separately in addition to code for primary procedure)**

Global: **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS Fastest Growing / High Volume Growth1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 06 **Specialty Developing Recommendation:** AANS/CNS, NASS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

22859 **Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 06 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,934

2021 Work RVU: 5.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.72

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22867 **Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level**

Global: 090 **Issue:** Insertion of Interlaminar/Interspinous Device **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 26 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,131

2021 Work RVU: 13.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.54

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

22868 **Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biomechancial Device Insertion-Intervertebral, Interbody **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 06 **Specialty Developing Recommendation:** AAOS, AANS, CNS, ISASS, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 532

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.96

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

22900 **Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 628

2021 Work RVU: 8.32
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.48

RUC Recommendation: 8.21 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

23076 **Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Subfascial Excision of Soft Tissue Tumor **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 677

2021 Work RVU: 7.41
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.02

RUC Recommendation: 7.28 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

23120 **Claviculectomy; partial**

Global: 090 **Issue:** Claviculectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 30 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 6,767

2021 Work RVU: 7.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.52

RUC Recommendation: 7.23 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23130 **Acromioplasty or acromionectomy, partial, with or without coracoacromial ligament release**

Global: 090 **Issue:** Removal of Bone **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,826

2021 Work RVU: 7.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.95

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

23350 **Injection procedure for shoulder arthrography or enhanced ct/mri shoulder arthrography**

Global: 000 **Issue:** Injection for Shoulder X-Ray **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** April 2011 **2019 est Medicare Utilization:** 35,070

2021 Work RVU: 1.00
2021 NF PE RVU: 3.80
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

23405 **Tenotomy, shoulder area; single tendon**

Global: 090 **Issue:** Tenotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,277

2021 Work RVU: 8.54
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.24

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

23410 **Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; acute**

Global: 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,333

2021 Work RVU: 11.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.61

RUC Recommendation: 11.23 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23412 **Repair of ruptured musculotendinous cuff (eg, rotator cuff) open; chronic** **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 12,002

2021 Work RVU: 11.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.91

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4. 11.77 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

23415 **Coracoacromial ligament release, with or without acromioplasty** **Global:** 090 **Issue:** Shoulder Ligament Release **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 62 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 408

2021 Work RVU: 9.23
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.58

RUC Recommendation: 9.23 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

23420 **Reconstruction of complete shoulder (rotator) cuff avulsion, chronic (includes acromioplasty)** **Global:** 090 **Issue:** Rotator Cuff **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,359

2021 Work RVU: 13.54
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.52

RUC Recommendation: 13.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

23430 **Tenodesis of long tendon of biceps**

Global: 090 **Issue:** Tenodesis **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 19,997

2021 Work RVU: 10.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.89

RUC Recommendation: 10.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

23440 **Resection or transplantation of long tendon of biceps**

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,487

2021 Work RVU: 10.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.61

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

23472 **Arthroplasty, glenohumeral joint; total shoulder (glenoid and proximal humeral replacement (eg, total shoulder))**

Global: 090 **Issue:** Arthroplasty **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2019 est Medicare Utilization:** 67,382

2021 Work RVU: 22.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.29

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

23540 **Closed treatment of acromioclavicular dislocation; without manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 339

2021 Work RVU: 2.36
2021 NF PE RVU: 4.19
2021 Fac PE RVU: 4.11

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

23600 **Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation** **Global:** 090 **Issue:** Treatment of Humerus Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 14 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2011 **2019 est Medicare Utilization:** 32,747

2021 Work RVU: 3.00
2021 NF PE RVU: 6.32
2021 Fac PE RVU: 5.76

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

23625 **Closed treatment of greater humeral tuberosity fracture; with manipulation** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 173

2021 Work RVU: 4.10
2021 NF PE RVU: 6.43
2021 Fac PE RVU: 5.50

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

23650 **Closed treatment of shoulder dislocation, with manipulation; without anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 14,692

2021 Work RVU: 3.53
2021 NF PE RVU: 5.37
2021 Fac PE RVU: 4.47

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

23655 **Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,327

2021 Work RVU: 4.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.41

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

23665 **Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 556

2021 Work RVU: 4.66
2021 NF PE RVU: 7.24
2021 Fac PE RVU: 6.24

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

24505 **Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 890

2021 Work RVU: 5.39
2021 NF PE RVU: 8.49
2021 Fac PE RVU: 6.96

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

24600 **Treatment of closed elbow dislocation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,283

2021 Work RVU: 4.37
2021 NF PE RVU: 5.82
2021 Fac PE RVU: 4.78

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

24605 **Treatment of closed elbow dislocation; requiring anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 382

2021 Work RVU: 5.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.43

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

25116 **Radical excision of bursa, synovia of wrist, or forearm tendon sheaths (eg, tenosynovitis, fungus, tbc, or other granulomas, rheumatoid arthritis); extensors, with or without transposition of dorsal retinaculum**

Global: 090 **Issue:** Forearm Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 63 **Specialty Developing Recommendation:** ASSH, AAOS, ASPS

First Identified: September 2007 **2019 est Medicare Utilization:** 1,034

2021 Work RVU: 7.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.89

RUC Recommendation: 7.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25210 **Carpectomy; 1 bone**

Global: 090 **Issue:** Carpectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS

First Identified: September 2007 **2019 est Medicare Utilization:** 3,150

2021 Work RVU: 6.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.35

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

25260 **Repair, tendon or muscle, flexor, forearm and/or wrist; primary, single, each tendon or muscle**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS

First Identified: September 2007 **2019 est Medicare Utilization:** 919

2021 Work RVU: 8.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.21

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

25280 **Lengthening or shortening of flexor or extensor tendon, forearm and/or wrist, single, each tendon**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,402

2021 Work RVU: 7.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.02

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

25310 **Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon**

Global: 090 **Issue:** Forearm Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 15 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,690

2021 Work RVU: 8.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.81

RUC Recommendation: 7.94 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

25565 **Closed treatment of radial and ulnar shaft fractures; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 667

2021 Work RVU: 5.85
2021 NF PE RVU: 8.38
2021 Fac PE RVU: 6.78

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

25605 **Closed treatment of distal radial fracture (eg, colles or smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 20,527

2021 Work RVU: 6.25
2021 NF PE RVU: 8.59
2021 Fac PE RVU: 7.68

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

25606 **Percutaneous skeletal fixation of distal radial fracture or epiphyseal separation** **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 2,015

2021 Work RVU: 8.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.77

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25607 **Open treatment of distal radial extra-articular fracture or epiphyseal separation, with internal fixation** **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 9,419

2021 Work RVU: 9.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.43

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25608 **Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 2 fragments** **Global:** 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** September 2014 **2019 est Medicare Utilization:** 7,290

2021 Work RVU: 11.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.23

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

25609 **Open treatment of distal radial intra-articular fracture or epiphyseal separation; with internal fixation of 3 or more fragments**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** January 2014 **2019 est Medicare Utilization:** 18,114

2021 Work RVU: 14.38
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.92

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

25675 **Closed treatment of distal radioulnar dislocation with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 445

2021 Work RVU: 4.89
2021 NF PE RVU: 7.39
2021 Fac PE RVU: 6.10

RUC Recommendation: PE Clinical staff pre-time revised

Referred to CPT **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

26020 **Drainage of tendon sheath, digit and/or palm, each**

Global: 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 2,453

2021 Work RVU: 6.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.34

RUC Recommendation: 7.79

Referred to CPT **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

26055 **Tendon sheath incision (eg, for trigger finger)**

Global: 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 105,433

2021 Work RVU: 3.11
2021 NF PE RVU: 13.80
2021 Fac PE RVU: 4.93

RUC Recommendation: 3.75

Referred to CPT **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

26080 **Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each**

Global: 090 **Issue:** RAW **Screen:** Site of Service Anomaly / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ASSH, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,997

2021 Work RVU: 4.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.50

RUC Recommendation: Action plan for RAW Oct 2015. Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2012

26160 **Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger**

Global: 090 **Issue:** Tendon Sheath Procedures **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 07 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2017 **2019 est Medicare Utilization:** 18,598

2021 Work RVU: 3.57
2021 NF PE RVU: 13.97
2021 Fac PE RVU: 5.13

RUC Recommendation: 3.57 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

26356 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); primary, without free graft, each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,150

2021 Work RVU: 9.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.28

RUC Recommendation: 10.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

26357 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, without free graft, each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2014 **2019 est Medicare Utilization:** 66

2021 Work RVU: 11.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.25

RUC Recommendation: 11.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

26358 **Repair or advancement, flexor tendon, in zone 2 digital flexor tendon sheath (eg, no man's land); secondary, with free graft (includes obtaining graft), each tendon**

Global: 090 **Issue:** Repair Flexor Tendon **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** April 2014 **2019 est Medicare Utilization:** 42

2021 Work RVU: 12.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.08

RUC Recommendation: 13.10 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

26480 **Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon**

Global: 090 **Issue:** Tendon Transfer **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 26 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** October 2008 **2019 est Medicare Utilization:** 10,824

2021 Work RVU: 6.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.38

RUC Recommendation: 6.76 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

26700 **Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 471

2021 Work RVU: 3.83
2021 NF PE RVU: 5.38
2021 Fac PE RVU: 4.61

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

26750 **Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,976

2021 Work RVU: 1.80
2021 NF PE RVU: 3.40
2021 Fac PE RVU: 3.43

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

26755 **Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 522

2021 Work RVU: 3.23
2021 NF PE RVU: 5.67
2021 Fac PE RVU: 4.32

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

26770 **Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,900

2021 Work RVU: 3.15
2021 NF PE RVU: 4.68
2021 Fac PE RVU: 3.93

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27048 **Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 05 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 339

2021 Work RVU: 8.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.31

RUC Recommendation: 8.74 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27062 **Excision; trochanteric bursa or calcification** **Global:** 090 **Issue:** Trochanteric Bursa Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 32 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,884

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.60

RUC Recommendation: 5.66 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27096 **Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or ct) including arthrography when performed** **Global:** 000 **Issue:** Injection for Sacroiliac Joint **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 06 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ASIPP, ISIS, NASS **First Identified:** October 2009 **2019 est Medicare Utilization:** 489,612

2021 Work RVU: 1.48
2021 NF PE RVU: 3.26
2021 Fac PE RVU: 0.81

RUC Recommendation: 1.48 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27130 **Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft** **Global:** 090 **Issue:** Hip/Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 169,584

2021 Work RVU: 19.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.40

RUC Recommendation: 19.60 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27134 **Revision of total hip arthroplasty; both components, with or without autograft or allograft**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,863

2021 Work RVU: 30.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.86

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27193 **Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; without manipulation**

Global: **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

27194 **Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation; with manipulation, requiring more than local anesthesia**

Global: **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27197 **Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation**

Global: 000 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:** 11,080

2021 Work RVU: 1.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.07

RUC Recommendation: 5.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27198 **Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; with manipulation, requiring more than local anesthesia (ie, general anesthesia, moderate sedation, spinal/epidural)**

Global: 000 **Issue:** Closed Treatment of Pelvic Ring Fracture **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2015 **2019 est Medicare Utilization:** 206

2021 Work RVU: 4.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.74

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27220 **Closed treatment of acetabulum (hip socket) fracture(s); without manipulation**

Global: 090 **Issue:** Closed Treatment Fracture - Hip **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 08 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2017 **2019 est Medicare Utilization:** 3,070

2021 Work RVU: 5.50
2021 NF PE RVU: 5.78
2021 Fac PE RVU: 5.61

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27230 **Closed treatment of femoral fracture, proximal end, neck; without manipulation** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,509

2021 Work RVU: 5.81
2021 NF PE RVU: 7.43
2021 Fac PE RVU: 7.17

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27232 **Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 194

2021 Work RVU: 11.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.83

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27236 **Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement** **Global:** 090 **Issue:** Open Treatment of Femoral Fracture **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2011 **2019 est Medicare Utilization:** 57,280

2021 Work RVU: 17.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.10

RUC Recommendation: 17.61 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27240 **Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 260

2021 Work RVU: 13.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.78

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27244 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with plate/screw type implant, with or without cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** April 2008 **2019 est Medicare Utilization:** 5,947

2021 Work RVU: 18.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.43

RUC Recommendation: 18.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

27245 **Treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with intramedullary implant, with or without interlocking screws and/or cerclage**

Global: 090 **Issue:** Treat Thigh Fracture **Screen:** High IWPUT / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 12 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 83,430

2021 Work RVU: 18.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.41

RUC Recommendation: 18.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27250 **Closed treatment of hip dislocation, traumatic; without anesthesia**

Global: 000 **Issue:** Closed Treatment of Hip Dislocation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 18 **Specialty Developing Recommendation:** ACEP **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,180

2021 Work RVU: 3.82
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.73

RUC Recommendation: 3.82 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27252 **Closed treatment of hip dislocation, traumatic; requiring anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 762

2021 Work RVU: 11.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.11

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27265 **Closed treatment of post hip arthroplasty dislocation; without anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 8,333

2021 Work RVU: 5.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.75

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27266 **Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia** **Global:** 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,456

2021 Work RVU: 7.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.98

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27279 **Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device** **Global:** 090 **Issue:** Arthodesis - Sacroiliac Joint **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 09 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** July 2017 **2019 est Medicare Utilization:** 3,753

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.28

RUC Recommendation: 9.03 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27324 **Biopsy, soft tissue of thigh or knee area; deep (subfascial or intramuscular)** **Global:** 090 **Issue:** Soft Tissue Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 814

2021 Work RVU: 5.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.87

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27369 **Injection procedure for contrast knee arthrography or contrast enhanced ct/mri knee arthrography**

Global: 000 **Issue:** Knee Arthrography Injection **Screen:** Harvard Valued - Utilization Over 30,000-Part2 / High Volume Growth3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 05 **Specialty Developing Recommendation:** ACR **First Identified:** June 2017 **2019 est Medicare Utilization:** 60,267

2021 Work RVU: 0.77
2021 NF PE RVU: 4.22
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.96 **Referred to CPT** February 2018 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27370 **Injection of contrast for knee arthrography**

Global: **Issue:** Knee Arthrography Injection **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / Harvard Valued - Utilization Over 30,000-Part2 / High Volume Growth3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 05 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Bulletin #1 2010

Status Report: CMS Requests and Relativity Assessment Issues

27446 **Arthroplasty, knee, condyle and plateau; medial or lateral compartment**

Global: 090 **Issue:** Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / Harvard-Valued with Annual Allowed Charges Greater than $10 million / Site of Service Anomaly - 2020 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 15,803

2021 Work RVU: 17.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.11

RUC Recommendation: 17.13 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27447 **Arthroplasty, knee, condyle and plateau; medial and lateral compartments with or without patella resurfacing (total knee arthroplasty)**

Global: 090 **Issue:** Hip/Knee Arthroplasty **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AAHKS **First Identified:** September 2011 **2019 est Medicare Utilization:** 312,130

2021 Work RVU: 19.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.37

RUC Recommendation: 19.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

27502 **Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 385

2021 Work RVU: 11.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.76

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27510 **Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 386

2021 Work RVU: 9.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.41

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27550 **Closed treatment of knee dislocation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 531

2021 Work RVU: 5.98
2021 NF PE RVU: 8.46
2021 Fac PE RVU: 7.25

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27552 **Closed treatment of knee dislocation; requiring anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 269

2021 Work RVU: 8.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.95

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27615 **Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm**

Global: 090 **Issue:** Radical Resecion of Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 6 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 211

2021 Work RVU: 15.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.22

RUC Recommendation: 15.54 **Referred to CPT** June 2008 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27619 **Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm**

Global: 090 **Issue:** Excision of Subfascial Soft Tissue Tumor Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 5 **Specialty Developing Recommendation:** ACS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 552

2021 Work RVU: 6.91
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.54

RUC Recommendation: 6.80 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27640 **Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); tibia**

Global: 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,673

2021 Work RVU: 12.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.13

RUC Recommendation: 12.10 **Referred to CPT** June 2008 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

27641 **Partial excision (craterization, saucerization, or diaphysectomy), bone (eg, osteomyelitis); fibula**

Global: 090 **Issue:** Leg Bone Resection Partial **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, AAOS **First Identified:** February 2008 **2019 est Medicare Utilization:** 905

2021 Work RVU: 9.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.91

RUC Recommendation: 9.72 **Referred to CPT** June 2008 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

27650 **Repair, primary, open or percutaneous, ruptured achilles tendon;**

Global: 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** 20 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,516

2021 Work RVU: 9.21
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.78

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27654 **Repair, secondary, achilles tendon, with or without graft**

Global: 090 **Issue:** Achilles Tendon Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 33 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,117

2021 Work RVU: 10.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.89

RUC Recommendation: 10.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27685 **Lengthening or shortening of tendon, leg or ankle; single tendon (separate procedure)**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,084

2021 Work RVU: 6.69
2021 NF PE RVU: 12.08
2021 Fac PE RVU: 6.05

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

27687 **Gastrocnemius recession (eg, strayer procedure)**

Global: 090 **Issue:** Tendon Repair **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,093

2021 Work RVU: 6.41
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.02

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

27690 **Transfer or transplant of single tendon (with muscle redirection or rerouting); superficial (eg, anterior tibial extensors into midfoot)**

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,376

2021 Work RVU: 9.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.39

RUC Recommendation: 8.96 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27691 **Transfer or transplant of single tendon (with muscle redirection or rerouting); deep (eg, anterior tibial or posterior tibial through interosseous space, flexor digitorum longus, flexor hallucis longus, or peroneal tendon to midfoot or hindfoot)**

Global: 090 **Issue:** Tendon Transfer **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 34 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,579

2021 Work RVU: 10.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.72

RUC Recommendation: 10.28 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27752 **Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,229

2021 Work RVU: 6.27
2021 NF PE RVU: 8.42
2021 Fac PE RVU: 7.06

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27762 **Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 369

2021 Work RVU: 5.47
2021 NF PE RVU: 7.69
2021 Fac PE RVU: 6.33

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

27792 **Open treatment of distal fibular fracture (lateral malleolus), includes internal fixation, when performed**

Global: 090 **Issue:** Treatment of Ankle Fracture **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 18 **Specialty Developing Recommendation:** AAOS, AOFAS, **First Identified:** June 2010 **2019 est Medicare Utilization:** 7,279

2021 Work RVU: 8.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.74

RUC Recommendation: 9.71 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

27810 **Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,962

2021 Work RVU: 5.32
2021 NF PE RVU: 7.64
2021 Fac PE RVU: 6.25

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27814 **Open treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli, or medial and posterior malleoli), includes internal fixation, when performed**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,858

2021 Work RVU: 10.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.01

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

27818 **Closed treatment of trimalleolar ankle fracture; with manipulation**

Global: 090 **Issue:** Treatment of Fracture **Screen:** Site of Service Anomaly (99238-Only) / Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,490

2021 Work RVU: 5.69
2021 NF PE RVU: 7.71
2021 Fac PE RVU: 6.15

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27825 **Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 659

2021 Work RVU: 6.69
2021 NF PE RVU: 8.17
2021 Fac PE RVU: 6.59

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

27840 **Closed treatment of ankle dislocation; without anesthesia**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,234

2021 Work RVU: 4.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.53

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

Status Report: CMS Requests and Relativity Assessment Issues

28001 **Incision and drainage, bursa, foot**

Global: 010 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** April 2020 **2019 est Medicare Utilization:** 3,770

2021 Work RVU: 2.78
2021 NF PE RVU: 5.09
2021 Fac PE RVU: 1.87

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28002 **Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space**

Global: 010 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:** 6,661

2021 Work RVU: 5.34
2021 NF PE RVU: 7.01
2021 Fac PE RVU: 3.34

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28003 **Incision and drainage below fascia, with or without tendon sheath involvement, foot; multiple areas**

Global: 090 **Issue:** Treatment of Foot Infection **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** April 2020 **2019 est Medicare Utilization:** 5,470

2021 Work RVU: 9.06
2021 NF PE RVU: 10.59
2021 Fac PE RVU: 6.33

RUC Recommendation: 5.28 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28111 **Ostectomy, complete excision; first metatarsal head**

Global: 090 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,069

2021 Work RVU: 5.15
2021 NF PE RVU: 8.71
2021 Fac PE RVU: 3.71

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28120 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); talus or calcaneus**

Global: 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,154

2021 Work RVU: 7.31
2021 NF PE RVU: 11.80
2021 Fac PE RVU: 6.30

RUC Recommendation: 8.27 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

28122 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus**

Global: 090 **Issue:** Removal of Foot Bone **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 19 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 14,469

2021 Work RVU: 6.76
2021 NF PE RVU: 10.10
2021 Fac PE RVU: 5.30

RUC Recommendation: 7.72 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28124 **Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); phalanx of toe**

Global: 090 **Issue:** Toe Removal **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 11,425

2021 Work RVU: 5.00
2021 NF PE RVU: 8.71
2021 Fac PE RVU: 4.25

RUC Recommendation: Remove 99238 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28285 **Correction, hammertoe (eg, interphalangeal fusion, partial or total phalangectomy)**

Global: 090 **Issue:** Orthopaedic Surgery/Podiatry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 31 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 71,537

2021 Work RVU: 5.62
2021 NF PE RVU: 9.73
2021 Fac PE RVU: 4.95

RUC Recommendation: 5.62 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

28289 **Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,662

2021 Work RVU: 6.90
2021 NF PE RVU: 13.18
2021 Fac PE RVU: 5.72

RUC Recommendation: 6.90 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28290 **Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg, Silver type procedure)**

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

28291 **Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,067

2021 Work RVU: 8.01
2021 NF PE RVU: 12.74
2021 Fac PE RVU: 5.60

RUC Recommendation: 8.01 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28292 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,950

2021 Work RVU: 7.44
2021 NF PE RVU: 12.86
2021 Fac PE RVU: 5.88

RUC Recommendation: 7.44 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

28293 **Correction, hallux valgus (bunion), with or without sesamoidectomy; resection of joint with implant**

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

28294 **Correction, hallux valgus (bunion), with or without sesamoidectomy; with tendon transplants (eg, Joplin type procedure)**

Global: **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28295 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal metatarsal osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 586

2021 Work RVU: 8.57
2021 NF PE RVU: 23.38
2021 Fac PE RVU: 8.29

RUC Recommendation: 8.57 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28296 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with distal metatarsal osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 9,559

2021 Work RVU: 8.25
2021 NF PE RVU: 17.86
2021 Fac PE RVU: 5.94

RUC Recommendation: 8.25 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28297 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with first metatarsal and medial cuneiform joint arthrodesis, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,793

2021 Work RVU: 9.29
2021 NF PE RVU: 20.85
2021 Fac PE RVU: 7.24

RUC Recommendation: 9.29 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28298 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with proximal phalanx osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,903

2021 Work RVU: 7.75
2021 NF PE RVU: 16.46
2021 Fac PE RVU: 6.00

RUC Recommendation: 7.75 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28299 **Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with double osteotomy, any method**

Global: 090 **Issue:** Bunionectomy **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 08 **Specialty Developing Recommendation:** AAOS, AOFAS, APMA **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,743

2021 Work RVU: 9.29
2021 NF PE RVU: 19.90
2021 Fac PE RVU: 6.82

RUC Recommendation: 9.29 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28300 **Osteotomy; calcaneus (eg, dwyer or chambers type procedure), with or without internal fixation**

Global: 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,519

2021 Work RVU: 9.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.88

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28310 **Osteotomy, shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)**

Global: 090 **Issue:** Osteotomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,640

2021 Work RVU: 5.57
2021 NF PE RVU: 10.09
2021 Fac PE RVU: 4.37

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28470 **Closed treatment of metatarsal fracture; without manipulation, each**

Global: 090 **Issue:** Treatment of Metatarsal Fracture **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 15 **Specialty Developing Recommendation:** AAOS, APMA, AOFAS **First Identified:** April 2011 **2019 est Medicare Utilization:** 29,629

2021 Work RVU: 2.03
2021 NF PE RVU: 4.14
2021 Fac PE RVU: 3.72

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28660 **Closed treatment of interphalangeal joint dislocation; without anesthesia**

Global: 010 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 689

2021 Work RVU: 1.28
2021 NF PE RVU: 2.07
2021 Fac PE RVU: 1.21

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2018

28725 **Arthrodesis; subtalar**

Global: 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,389

2021 Work RVU: 11.22
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.84

RUC Recommendation: 12.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

28730 **Arthrodesis, midtarsal or tarsometatarsal, multiple or transverse;**

Global: 090 **Issue:** Foot Arthrodesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 20 **Specialty Developing Recommendation:** AOFAS, APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,581

2021 Work RVU: 10.70
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.25

RUC Recommendation: 12.42 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

28740 **Arthrodesis, midtarsal or tarsometatarsal, single joint**

Global: 090 **Issue:** Arthrodesis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,996

2021 Work RVU: 9.29
2021 NF PE RVU: 14.18
2021 Fac PE RVU: 7.58

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

28820 **Amputation, toe; metatarsophalangeal joint**

Global: 000 **Issue:** Toe Amputation **Screen:** Site of Service Anomaly - 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, ACS, AOFAS, APMA, SVS **First Identified:** October 2018 **2019 est Medicare Utilization:** 30,702

2021 Work RVU: 3.51
2021 NF PE RVU: 5.16
2021 Fac PE RVU: 1.34

RUC Recommendation: 4.10 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

28825 **Amputation, toe; interphalangeal joint**

Global: 000 **Issue:** Toe Amputation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, ACS, AOFAS, APMA, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 15,013

2021 Work RVU: 3.41
2021 NF PE RVU: 5.09
2021 Fac PE RVU: 1.30

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29075 **Application, cast; elbow to finger (short arm)**

Global: 000 **Issue:** Application of Forearm Cast **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 16 **Specialty Developing Recommendation:** AAOS, ASSH **First Identified:** April 2011 **2019 est Medicare Utilization:** 68,396

2021 Work RVU: 0.77
2021 NF PE RVU: 1.62
2021 Fac PE RVU: 0.90

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29105 **Application of long arm splint (shoulder to hand)**

Global: 000 **Issue:** Application of Long Arm Splint **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAOS, ACEP, ASSH **First Identified:** July 2016 **2019 est Medicare Utilization:** 25,626

2021 Work RVU: 0.80
2021 NF PE RVU: 1.45
2021 Fac PE RVU: 0.29

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29200 **Strapping; thorax**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,693

2021 Work RVU: 0.39
2021 NF PE RVU: 0.56
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29220 **Deleted from CPT**

Global: **Issue:** Strapping; low back **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted from CPT, no further action necessary

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29240 **Strapping; shoulder (eg, velpeau)**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 16,307

2021 Work RVU: 0.39
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29260 **Strapping; elbow or wrist**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** October 2013 **2019 est Medicare Utilization:** 5,004

2021 Work RVU: 0.39
2021 NF PE RVU: 0.45
2021 Fac PE RVU: 0.14

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29280 **Strapping; hand or finger**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** October 2013 **2019 est Medicare Utilization:** 3,404

2021 Work RVU: 0.39
2021 NF PE RVU: 0.43
2021 Fac PE RVU: 0.14

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29445 **Application of rigid total contact leg cast**

Global: 000 **Issue:** Application of Rigid Leg Cast **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, AHKNS, AOFAS, AOA, NASS **First Identified:** October 2015 **2019 est Medicare Utilization:** 36,431

2021 Work RVU: 1.78
2021 NF PE RVU: 1.78
2021 Fac PE RVU: 0.94

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29520 **Strapping; hip**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,018

2021 Work RVU: 0.39
2021 NF PE RVU: 0.64
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29530 **Strapping; knee**

Global: 000 **Issue:** Strapping Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 35 **Specialty Developing Recommendation:** APTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 27,045

2021 Work RVU: 0.39
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.12

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29540 **Strapping; ankle and/or foot**

Global: 000 **Issue:** Strapping Lower Extremity **Screen:** Harvard Valued - Utilization over 100,000 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41ii **Specialty Developing Recommendation:** APMA **First Identified:** October 2009 **2019 est Medicare Utilization:** 213,060

2021 Work RVU: 0.39
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.09

RUC Recommendation: 0.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29550 **Strapping; toes**

Global: 000 **Issue:** Strapping Lower Extremity **Screen:** Harvard Valued - Utilization over 100,000 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41ii **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2019 est Medicare Utilization:** 56,200

2021 Work RVU: 0.25
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29580 **Strapping; unna boot**

Global: 000 **Issue:** Strapping Multi Layer Compression **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 13 **Specialty Developing Recommendation:** ACS, APMA, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 265,752

2021 Work RVU: 0.55
2021 NF PE RVU: 1.26
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29581 **Application of multi-layer compression system; leg (below knee), including ankle and foot**

Global: 000 **Issue:** Strapping Multi Layer Compression **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 13 **Specialty Developing Recommendation:** ACS, APMA, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 194,064

2021 Work RVU: 0.60
2021 NF PE RVU: 2.03
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29582 **Application of multi-layer compression system; thigh and leg, including ankle and foot, when performed**

Global: **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

29583 **Application of multi-layer compression system; upper arm and forearm**

Global: **Issue:** New Technology Review **Screen:** New Technology/New Services **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

Status Report: CMS Requests and Relativity Assessment Issues

29584 **Application of multi-layer compression system; upper arm, forearm, hand, and fingers**

Global: 000 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis **Complete?** No

Most Recent RUC Meeting: October 2018 **Tab:** 27 **Specialty Developing Recommendation:** APTA **First Identified:** October 2015 **2019 est Medicare Utilization:** 2,715

2021 Work RVU: 0.35
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.10

RUC Recommendation: Develop CPT Assistant Article **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2016

29590 **Denis-Browne splint strapping**

Global: **Issue:** Dennis-Browne splint revision **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 07 **Specialty Developing Recommendation:** APMA **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

29805 **Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 698

2021 Work RVU: 6.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.74

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29822 **Arthroscopy, shoulder, surgical; debridement, limited, 1 or 2 discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])**

Global: 090 **Issue:** Shoulder Debridement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 11 **Specialty Developing Recommendation:**

First Identified: October 2008 **2019 est Medicare Utilization:** 9,153

2021 Work RVU: 7.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.61

RUC Recommendation: 7.03 **Referred to CPT** September 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29823 **Arthroscopy, shoulder, surgical; debridement, extensive, 3 or more discrete structures (eg, humeral bone, humeral articular cartilage, glenoid bone, glenoid articular cartilage, biceps tendon, biceps anchor complex, labrum, articular capsule, articular side of the rotator cuff, bursal side of the rotator cuff, subacromial bursa, foreign body[ies])**

Global: 090 **Issue:** Shoulder Debridement **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / Harvard Valued - Utilization over 30,000-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 11 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:** 45,349

2021 Work RVU: 7.98
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.03

RUC Recommendation: 7.98 **Referred to CPT** September 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29824 **Arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface (mumford procedure)**

Global: 090 **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS

First Identified: February 2010 **2019 est Medicare Utilization:** 39,895

2021 Work RVU: 8.98
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.29

RUC Recommendation: 8.82 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29826 **Arthroscopy, shoulder, surgical; decompression of subacromial space with partial acromioplasty, with coracoacromial ligament (ie, arch) release, when performed (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 78,655

2021 Work RVU: 3.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.52

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

29827 **Arthroscopy, shoulder, surgical; with rotator cuff repair**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing/ Codes Reported Together 75% or More-Part1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** October 2008 **2019 est Medicare Utilization:** 69,465

2021 Work RVU: 15.59
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.97

RUC Recommendation: 15.59. Maintain work RVU and adjust the times from pre-time package 3. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

29828 **Arthroscopy, shoulder, surgical; biceps tenodesis**

Global: 090 **Issue:** RAW **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAOS **First Identified:** February 2010 **2019 est Medicare Utilization:** 18,992

2021 Work RVU: 13.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.38

RUC Recommendation: 13.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29830 **Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 136

2021 Work RVU: 5.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.50

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29840 **Arthroscopy, wrist, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 125

2021 Work RVU: 5.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.66

RUC Recommendation: No NF PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29870 **Arthroscopy, knee, diagnostic, with or without synovial biopsy (separate procedure)**

Global: 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 13 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 1,031

2021 Work RVU: 5.19
2021 NF PE RVU: 10.58
2021 Fac PE RVU: 5.85

RUC Recommendation: New PE non-facility inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

29888 **Arthroscopically aided anterior cruciate ligament repair/augmentation or reconstruction**

Global: 090 **Issue:** ACL Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 38 **Specialty Developing Recommendation:** AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,173

2021 Work RVU: 14.30
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.84

RUC Recommendation: 14.14 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

29900 **Arthroscopy, metacarpophalangeal joint, diagnostic, includes synovial biopsy** **Global:** 090 **Issue:** Arthroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 51 **Specialty Developing Recommendation:** AAOS **First Identified:** NA **2019 est Medicare Utilization:** 4

2021 Work RVU: 5.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.79

RUC Recommendation: No NF PE inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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30140 **Submucous resection inferior turbinate, partial or complete, any method** **Global:** 000 **Issue:** Resection of Inferior Turbinate **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 14 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 49,954

2021 Work RVU: 3.00
2021 NF PE RVU: 5.28
2021 Fac PE RVU: 1.75

RUC Recommendation: 3.00 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Decrease

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30465 **Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)** **Global:** 090 **Issue:** Repair Nasal Stenosis **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,626

2021 Work RVU: 12.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.15

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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Status Report: CMS Requests and Relativity Assessment Issues

30901 **Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 88,372

2021 Work RVU: 1.10
2021 NF PE RVU: 3.36
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

30903 **Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 48,496

2021 Work RVU: 1.54
2021 NF PE RVU: 5.49
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

30905 **Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 5,245

2021 Work RVU: 1.97
2021 NF PE RVU: 8.29
2021 Fac PE RVU: 0.78

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

30906 **Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent**

Global: 000 **Issue:** Control Nasal Hemorrhage **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 20 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 800

2021 Work RVU: 2.45
2021 NF PE RVU: 8.13
2021 Fac PE RVU: 1.14

RUC Recommendation: 2.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31231 **Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2010 **2019 est Medicare Utilization:** 660,545

2021 Work RVU: 1.10
2021 NF PE RVU: 4.54
2021 Fac PE RVU: 0.61

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31237 **Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement (separate procedure)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 137,754

2021 Work RVU: 2.60
2021 NF PE RVU: 4.56
2021 Fac PE RVU: 1.65

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31238 **Nasal/sinus endoscopy, surgical; with control of nasal hemorrhage**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 29,505

2021 Work RVU: 2.74
2021 NF PE RVU: 4.25
2021 Fac PE RVU: 1.71

RUC Recommendation: 2.74 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31239 **Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy**

Global: 010 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,366

2021 Work RVU: 9.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.80

RUC Recommendation: 9.04 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31240 **Nasal/sinus endoscopy, surgical; with concha bullosa resection**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 6,458

2021 Work RVU: 2.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.62

RUC Recommendation: 2.61 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31241 **Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 470

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.78

RUC Recommendation: 8.51 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31253 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including frontal sinus exploration, with removal of tissue from frontal sinus, when performed**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 8,502

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.26

RUC Recommendation: 9.00 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31254 **Nasal/sinus endoscopy, surgical with ethmoidectomy; partial (anterior)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 13,255

2021 Work RVU: 4.27
2021 NF PE RVU: 8.03
2021 Fac PE RVU: 2.19

RUC Recommendation: 4.27 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31255 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior)**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 11,287

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.84

RUC Recommendation: 5.75 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31256 **Nasal/sinus endoscopy, surgical, with maxillary antrostomy;**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 15,592

2021 Work RVU: 3.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.68

RUC Recommendation: 3.11 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31257 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 5,920

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.83

RUC Recommendation: 8.00 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31259 **Nasal/sinus endoscopy, surgical with ethmoidectomy; total (anterior and posterior), including sphenoidotomy, with removal of tissue from the sphenoid sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 7,903

2021 Work RVU: 8.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.04

RUC Recommendation: 8.48 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31267 **Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 28,703

2021 Work RVU: 4.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.36

RUC Recommendation: 4.68 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31276 **Nasal/sinus endoscopy, surgical, with frontal sinus exploration, including removal of tissue from frontal sinus, when performed**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 15,859

2021 Work RVU: 6.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.27

RUC Recommendation: 6.75 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31287 **Nasal/sinus endoscopy, surgical, with sphenoidotomy;**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 3,280

2021 Work RVU: 3.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.84

RUC Recommendation: 3.50 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31288 **Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 4,121

2021 Work RVU: 4.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.11

RUC Recommendation: 4.10 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31295 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 28,533

2021 Work RVU: 2.70
2021 NF PE RVU: 52.30
2021 Fac PE RVU: 1.50

RUC Recommendation: 2.70 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

31296 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 8,725

2021 Work RVU: 3.10
2021 NF PE RVU: 52.59
2021 Fac PE RVU: 1.67

RUC Recommendation: 3.10 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31297 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 2,120

2021 Work RVU: 2.44
2021 NF PE RVU: 52.17
2021 Fac PE RVU: 1.38

RUC Recommendation: 2.44 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31298 **Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal and sphenoid sinus ostia**

Global: 000 **Issue:** Nasal/Sinus Endoscopy **Screen:** Codes Reported Together 75% or More-Part3 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAOHNS **First Identified:** April 2015 **2019 est Medicare Utilization:** 19,499

2021 Work RVU: 4.50
2021 NF PE RVU: 99.88
2021 Fac PE RVU: 2.28

RUC Recommendation: 4.50 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31500 **Intubation, endotracheal, emergency procedure**

Global: 000 **Issue:** Endotracheal Intubation **Screen:** CMS High Expenditure Procedural Codes2 / Modifer -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 27 **Specialty Developing Recommendation:** ACEP, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 263,123

2021 Work RVU: 3.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.72

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2016

Status Report: CMS Requests and Relativity Assessment Issues

31551 **Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 2

2021 Work RVU: 21.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 20.58

RUC Recommendation: 21.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31552 **Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 12

2021 Work RVU: 20.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 20.16

RUC Recommendation: 20.50 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31553 **Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU: 22.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.58

RUC Recommendation: 22.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31554 **Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 23

2021 Work RVU: 22.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.60

RUC Recommendation: 22.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31571 **Laryngoscopy, direct, with injection into vocal cord(s), therapeutic; with operating microscope or telescope**

Global: 000 **Issue:** Laryngoscopy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS

First Identified: September 2007 **2019 est Medicare Utilization:** 5,271

2021 Work RVU: 4.26
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.32

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

31575 **Laryngoscopy, flexible; diagnostic**

Global: 000 **Issue:** **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 08 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2010 **2019 est Medicare Utilization:** 658,434

2021 Work RVU: 0.94
2021 NF PE RVU: 2.69
2021 Fac PE RVU: 0.87

RUC Recommendation: 1.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

31579 **Laryngoscopy, flexible or rigid telescopic, with stroboscopy**

Global: 000 **Issue:** Laryngoscopy **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 08 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2008 **2019 est Medicare Utilization:** 86,928

2021 Work RVU: 1.88
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 1.31

RUC Recommendation: 1.94

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

31580 **Laryngoplasty; for laryngeal web, with indwelling keel or stent insertion**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 21

2021 Work RVU: 14.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 21.35

RUC Recommendation: 14.60 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31582 **Laryngoplasty; for laryngeal stenosis, with graft or core mold, including tracheotomy**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

31584 **Laryngoplasty; with open reduction and fixation of (eg, plating) fracture, includes tracheostomy, if performed**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 15

2021 Work RVU: 17.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 21.83

RUC Recommendation: 20.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31587 **Laryngoplasty, cricoid split, without graft placement**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2014 **2019 est Medicare Utilization:** 15

2021 Work RVU: 15.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.87

RUC Recommendation: 15.27 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31588 **Laryngoplasty, not otherwise specified (eg, for burns, reconstruction after partial laryngectomy)**

Global: **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

31591 **Laryngoplasty, medialization, unilateral**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 1,148

2021 Work RVU: 13.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.65

RUC Recommendation: 15.60 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31592 **Cricotracheal resection**

Global: 090 **Issue:** Laryngoplasty **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 09 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 23

2021 Work RVU: 25.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 22.15

RUC Recommendation: 25.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31600 **Tracheostomy, planned (separate procedure);**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 23,498

2021 Work RVU: 5.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.38

RUC Recommendation: 5.56 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31601 **Tracheostomy, planned (separate procedure); younger than 2 years**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 4

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.93

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

31603 **Tracheostomy, emergency procedure; transtracheal**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 801

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.34

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

31605 **Tracheostomy, emergency procedure; cricothyroid membrane**

Global: 000 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAOHNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 278

2021 Work RVU: 6.45
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.02

RUC Recommendation: 6.45 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

31610 **Tracheostomy, fenestration procedure with skin flaps**

Global: 090 **Issue:** Tracheostomy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 15 **Specialty Developing Recommendation:** AAOHNS, ACS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,593

2021 Work RVU: 12.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.66

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31611 **Construction of tracheoesophageal fistula and subsequent insertion of an alaryngeal speech prosthesis (eg, voice button, blom-singer prosthesis)**

Global: 090 **Issue:** Speech Prosthesis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 761

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.01

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

31620 **Endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) (List separately in addition to code for primary procedure[s])**

Global: **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

31622 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 52,315

2021 Work RVU: 2.53
2021 NF PE RVU: 4.51
2021 Fac PE RVU: 1.03

RUC Recommendation: 2.78 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31623 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with brushing or protected brushings**

Global: 000 **Issue:** Diagnostic Bronchoscopy **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 09 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2016 **2019 est Medicare Utilization:** 26,278

2021 Work RVU: 2.63
2021 NF PE RVU: 5.36
2021 Fac PE RVU: 1.01

RUC Recommendation: 2.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31624 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial alveolar lavage**

Global: 000 **Issue:** Diagnostic Bronchoscopy **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 09 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2017 **2019 est Medicare Utilization:** 118,565

2021 Work RVU: 2.63
2021 NF PE RVU: 4.74
2021 Fac PE RVU: 1.04

RUC Recommendation: 2.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31625 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with bronchial or endobronchial biopsy(s), single or multiple sites**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2013 **2019 est Medicare Utilization:** 19,149

2021 Work RVU: 3.11
2021 NF PE RVU: 7.16
2021 Fac PE RVU: 1.17

RUC Recommendation: 3.36 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31626 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,173

2021 Work RVU: 3.91
2021 NF PE RVU: 21.01
2021 Fac PE RVU: 1.42

RUC Recommendation: 4.16 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31628 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 32,291

2021 Work RVU: 3.55
2021 NF PE RVU: 7.37
2021 Fac PE RVU: 1.30

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31629 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), trachea, main stem and/or lobar bronchus(i)**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 13,745

2021 Work RVU: 3.75
2021 NF PE RVU: 9.78
2021 Fac PE RVU: 1.36

RUC Recommendation: 4.00 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31632 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), each additional lobe (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,890

2021 Work RVU: 1.03
2021 NF PE RVU: 0.77
2021 Fac PE RVU: 0.32

RUC Recommendation: 1.03 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

31633 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial needle aspiration biopsy(s), each additional lobe (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,196

2021 Work RVU: 1.32
2021 NF PE RVU: 0.93
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31645 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 08 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2015 **2019 est Medicare Utilization:** 35,233

2021 Work RVU: 2.88
2021 NF PE RVU: 4.90
2021 Fac PE RVU: 1.13

RUC Recommendation: 2.88 **Referred to CPT** May 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

31646 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, subsequent, same hospital stay**

Global: 000 **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 08 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,580

2021 Work RVU: 2.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.09

RUC Recommendation: 2.78 **Referred to CPT** May 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

31652 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 25,507

2021 Work RVU: 4.46
2021 NF PE RVU: 32.45
2021 Fac PE RVU: 1.59

RUC Recommendation: 5.00 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

31653 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures**

Global: 000 **Issue:** Endobronchial Ultrasound - EBUS **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 13,988

2021 Work RVU: 4.96
2021 NF PE RVU: 33.33
2021 Fac PE RVU: 1.74

RUC Recommendation: 5.50 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

31654 **Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (ebus) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (list separately in addition to code for primary procedure[s])**

Global: ZZZ **Issue:** Bronchial Aspiration of Tracheobronchial Tree **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 05 **Specialty Developing Recommendation:** ATS, ACCP **First Identified:** October 2014 **2019 est Medicare Utilization:** 8,214

2021 Work RVU: 1.40
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.70 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

32201 **Pneumonostomy; with percutaneous drainage of abscess or cyst**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32405 **Biopsy, lung or mediastinum, percutaneous needle**

Global: **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 05 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 70,068

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

32408 **Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed**

Global: 000 **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 05 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** April 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 3.18
2021 NF PE RVU: 24.27
2021 Fac PE RVU: 1.00

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

32420 **Pneumocentesis, puncture of lung for aspiration**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32421 **Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

32422 **Thoracentesis with insertion of tube, includes water seal (eg, for pneumothorax), when performed (separate procedure)**

Global: **Issue:** Thoracentesis with Tube Insertion **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 17 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR, SCCM, STS **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

32440 **Removal of lung, pneumonectomy;**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 247

2021 Work RVU: 27.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.36

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32480 **Removal of lung, other than pneumonectomy; single lobe (lobectomy)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 4,630

2021 Work RVU: 25.82
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.53

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

32482 **Removal of lung, other than pneumonectomy; 2 lobes (bilobectomy)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 294

2021 Work RVU: 27.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.58

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures.

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

32491 **Removal of lung, other than pneumonectomy; with resection-plication of emphysematous lung(s) (bullous or non-bullous) for lung volume reduction, sternal split or transthoracic approach, includes any pleural procedure, when performed**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** November 2011 **2019 est Medicare Utilization:** 15

2021 Work RVU: 25.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.02

RUC Recommendation: Request further information from CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32551 **Tube thoracostomy, includes connection to drainage system (eg, water seal), when performed, open (separate procedure)**

Global: 000 **Issue:** Chest Tube Thoracostomy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACCP, ATS, ACR, ACS, SIR, SCCM, STS **First Identified:** April 2011 **2019 est Medicare Utilization:** 33,044

2021 Work RVU: 3.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.01

RUC Recommendation: 3.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

32554 **Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 13,649

2021 Work RVU: 1.82
2021 NF PE RVU: 5.07
2021 Fac PE RVU: 0.60

RUC Recommendation: 1.82 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

32555 **Thoracentesis, needle or catheter, aspiration of the pleural space; with imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 229,865

2021 Work RVU: 2.27
2021 NF PE RVU: 7.14
2021 Fac PE RVU: 0.75

RUC Recommendation: 2.27 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

32556 **Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,833

2021 Work RVU: 2.50
2021 NF PE RVU: 19.31
2021 Fac PE RVU: 0.80

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

32557 **Pleural drainage, percutaneous, with insertion of indwelling catheter; with imaging guidance**

Global: 000 **Issue:** Chest Tube Interventions **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 04 **Specialty Developing Recommendation:** ACCP, ACR, ATS, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 38,244

2021 Work RVU: 3.12
2021 NF PE RVU: 16.44
2021 Fac PE RVU: 0.98

RUC Recommendation: 3.62 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

32663 **Thoracoscopy, surgical; with lobectomy (single lobe)**

Global: 090 **Issue:** RAW review **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** STS **First Identified:** October 2008 **2019 est Medicare Utilization:** 9,229

2021 Work RVU: 24.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.61

RUC Recommendation: No reliable way to determine incremental difference between open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

33010 **Pericardiocentesis; initial**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 6,698

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

33011 **Pericardiocentesis; subsequent**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 87

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33015 **Tube pericardiostomy**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2017 **2019 est Medicare Utilization:** 1,147

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

33016 **Pericardiocentesis, including imaging guidance, when performed**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.55

RUC Recommendation: 5.00 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

33017 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.60

RUC Recommendation: 5.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33018 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; birth through 5 years of age or any age with congenital cardiac anomaly**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 5.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.72

RUC Recommendation: 6.00 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

33019 **Pericardial drainage with insertion of indwelling catheter, percutaneous, including ct guidance**

Global: 000 **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.49

RUC Recommendation: 5.00 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

33020 **Pericardiotomy for removal of clot or foreign body (primary procedure)**

Global: 090 **Issue:** Pericardiotomy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 10 **Specialty Developing Recommendation:** AATS, STS **First Identified:** April 2018 **2019 est Medicare Utilization:** 122

2021 Work RVU: 14.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.59

RUC Recommendation: 14.31 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

33025 **Creation of pericardial window or partial resection for drainage**

Global: 090 **Issue:** Pericardiotomy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 10 **Specialty Developing Recommendation:** AATS, STS **First Identified:** April 2017 **2019 est Medicare Utilization:** 4,535

2021 Work RVU: 13.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.29

RUC Recommendation: 13.20 **Referred to CPT** May 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33207 **Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); ventricular**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,733

2021 Work RVU: 7.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.56

RUC Recommendation: 8.05 **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33208 **Insertion of new or replacement of permanent pacemaker with transvenous electrode(s); atrial and ventricular**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 103,628

2021 Work RVU: 8.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.88

RUC Recommendation: 8.77 **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33212 **Insertion of pacemaker pulse generator only; with existing single lead**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 317

2021 Work RVU: 5.01
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.37

RUC Recommendation: 5.26 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33213 **Insertion of pacemaker pulse generator only; with existing dual leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,113

2021 Work RVU: 5.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.43

RUC Recommendation: 5.53 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33221 **Insertion of pacemaker pulse generator only; with existing multiple leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 268

2021 Work RVU: 5.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.87

RUC Recommendation: 5.80 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33227 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; single lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 3,452

2021 Work RVU: 5.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.56

RUC Recommendation: 5.50 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33228 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; dual lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 24,395

2021 Work RVU: 5.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.68

RUC Recommendation: 5.77 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33229 **Removal of permanent pacemaker pulse generator with replacement of pacemaker pulse generator; multiple lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,526

2021 Work RVU: 5.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.96

RUC Recommendation: 6.04 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33230 **Insertion of implantable defibrillator pulse generator only; with existing dual leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 140

2021 Work RVU: 6.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.86

RUC Recommendation: 6.32 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33231 **Insertion of implantable defibrillator pulse generator only; with existing multiple leads**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC

First Identified: April 2011

2019 est Medicare Utilization: 121

2021 Work RVU: 6.34
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.04

RUC Recommendation: 6.59

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

33233 **Removal of permanent pacemaker pulse generator only**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC

First Identified: February 2010

2019 est Medicare Utilization: 8,743

2021 Work RVU: 3.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.01

RUC Recommendation: 3.39

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

33240 **Insertion of implantable defibrillator pulse generator only; with existing single lead**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC

First Identified: February 2010

2019 est Medicare Utilization: 217

2021 Work RVU: 5.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.64

RUC Recommendation: 6.06

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

33241 **Removal of implantable defibrillator pulse generator only**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,043

2021 Work RVU: 3.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.61

RUC Recommendation: 3.29 **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33249 **Insertion or replacement of permanent implantable defibrillator system, with transvenous lead(s), single or dual chamber**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 42,661

2021 Work RVU: 14.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.73

RUC Recommendation: 15.17 **Referred to CPT** February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33262 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; single lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** April 2011 **2019 est Medicare Utilization:** 3,000

2021 Work RVU: 5.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.90

RUC Recommendation: 6.06 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33263 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; dual lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC

First Identified: April 2011

2019 est Medicare Utilization: 7,980

2021 Work RVU: 6.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.01

RUC Recommendation: 6.33

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

33264 **Removal of implantable defibrillator pulse generator with replacement of implantable defibrillator pulse generator; multiple lead system**

Global: 090 **Issue:** Pacemaker or Pacing Carioverter - Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 04 **Specialty Developing Recommendation:** ACC

First Identified: April 2011

2019 est Medicare Utilization: 11,831

2021 Work RVU: 6.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.17

RUC Recommendation: 6.60

Referred to CPT February 2011

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

33282 **Implantation of patient-activated cardiac event recorder**

Global: **Issue:** Implantation and Removal of Patient Activated Cardiac Event Recorder **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 3.50

Referred to CPT February 2017

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

33284 **Removal of an implantable, patient-activated cardiac event recorder**

Global: **Issue:** Implantation and Removal of Patient Activated Cardiac Event Recorder **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 3.00 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

33405 **Replacement, aortic valve, open, with cardiopulmonary bypass; with prosthetic valve other than homograft or stentless valve**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 40 **Specialty Developing Recommendation:** STS

First Identified: September 2011 **2019 est Medicare Utilization:** 17,344

2021 Work RVU: 41.32
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.58

RUC Recommendation: 41.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33430 **Replacement, mitral valve, with cardiopulmonary bypass**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** High IWPUT / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 40 **Specialty Developing Recommendation:** STS

First Identified: February 2008 **2019 est Medicare Utilization:** 7,658

2021 Work RVU: 50.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.29

RUC Recommendation: 50.93 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33533 **Coronary artery bypass, using arterial graft(s); single arterial graft**

Global: 090 **Issue:** Valve Replacement and CABG Procedures **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 40 **Specialty Developing Recommendation:** STS

First Identified: September 2011 **2019 est Medicare Utilization:** 60,180

2021 Work RVU: 33.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.23

RUC Recommendation: 34.98 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

33620 **Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** STS

First Identified: January 2015 **2019 est Medicare Utilization:** 56

2021 Work RVU: 30.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.30

RUC Recommendation: CPT Article published July 2016. Maintain, CPT Assistant addressed issues identified. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

33621 **Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** STS

First Identified: January 2015 **2019 est Medicare Utilization:**

2021 Work RVU: 16.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.30

RUC Recommendation: CPT Article published July 2016. Maintain, CPT Assistant addressed issues identified. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

Status Report: CMS Requests and Relativity Assessment Issues

33622 **Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, norwood, bidirectional glenn, pulmonary artery debanding)**

Global: 090 **Issue:** New Technology Review **Screen:** New Technology/New Services / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** STS **First Identified:** January 2015 **2019 est Medicare Utilization:** 1

2021 Work RVU: 64.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 21.49

RUC Recommendation: CPT Article published July 2016. Maintain, CPT Assistant addressed issues identified.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2016

33741 **Transcatheter atrial septostomy (tas) for congenital cardiac anomalies to create effective atrial flow, including all imaging guidance by the proceduralist, when performed, any method (eg, rashkind, sang-park, balloon, cutting balloon, blade)**

Global: 000 **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** September 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 14.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.98

RUC Recommendation: 14.00

Referred to CPT September 2019 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33745 **Transcatheter intracardiac shunt (tis) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, fontan fenestration, right ventricular outflow tract, mustard/senning/warden baffles); initial intracardiac shunt**

Global: 000 **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** September 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 20.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.24

RUC Recommendation: 20.00

Referred to CPT September 2019 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33746 **Transcatheter intracardiac shunt (tis) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, fontan fenestration, right ventricular outflow tract, mustard/senning/warden baffles); each additional intracardiac shunt location (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** September 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.88

RUC Recommendation: 10.50 **Referred to CPT** September 2019 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33863 **Ascending aorta graft, with cardiopulmonary bypass, with aortic root replacement using valved conduit and coronary reconstruction (eg, bentall)**

Global: 090 **Issue:** Aortic Graft **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** STS, AATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,812

2021 Work RVU: 58.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.72

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

33945 **Heart transplant, with or without recipient cardiectomy**

Global: 090 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 667

2021 Work RVU: 89.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 31.88

RUC Recommendation: 16.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33946 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; initiation, veno-venous** **Global:** XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2014 **2019 est Medicare Utilization:** 603

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.82

RUC Recommendation: 6.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33947 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; initiation, veno-arterial** **Global:** XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 1,395

2021 Work RVU: 6.63
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.00

RUC Recommendation: 6.63 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33948 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; daily management, each day, veno-venous** **Global:** XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 4,436

2021 Work RVU: 4.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.49

RUC Recommendation: 4.73 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33949 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; daily management, each day, veno-arterial** **Global:** XXX **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** November 2013 **2019 est Medicare Utilization:** 5,342

2021 Work RVU: 4.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.41

RUC Recommendation: 4.60 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33951 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 1

2021 Work RVU: 8.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.36

RUC Recommendation: 8.15 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33952 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 1,439

2021 Work RVU: 8.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.56

RUC Recommendation: 8.43 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33953 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:**

2021 Work RVU: 9.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.63

RUC Recommendation: 9.83 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33954 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 354

2021 Work RVU: 9.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 9.43 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33956 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 352

2021 Work RVU: 16.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.73

RUC Recommendation: 16.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33957 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.08

RUC Recommendation: 4.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33958 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 72

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.08

RUC Recommendation: 4.05 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33959 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 4.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.35

RUC Recommendation: 4.69 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33960 **Prolonged extracorporeal circulation for cardiopulmonary insufficiency; initial day**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33961 **Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI, ACCP **First Identified:** July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

33962 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 20

2021 Work RVU: 4.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.35

RUC Recommendation: 4.73 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

33963 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.60

RUC Recommendation: 9.00 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33964 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 22

2021 Work RVU: 9.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 9.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33965 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.08

RUC Recommendation: 3.51 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33966 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 383

2021 Work RVU: 4.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.44

RUC Recommendation: 4.50 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33969 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 5.22
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.56

RUC Recommendation: 6.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33984 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 543

2021 Work RVU: 5.46
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.58

RUC Recommendation: 6.38 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33985 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 1

2021 Work RVU: 9.89
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.85

RUC Recommendation: 9.89 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33986 **Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 221

2021 Work RVU: 10.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.99

RUC Recommendation: 10.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33987 **Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ecmo/ecls (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 41

2021 Work RVU: 4.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.13

RUC Recommendation: 4.08 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

33988 **Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ecmo/ecls**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2014 **2019 est Medicare Utilization:** 40

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.28

RUC Recommendation: 15.00 **Referred to CPT** February 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

33989 **Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ecmo/ecls**

Global: 000 **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** November 2013 **2019 est Medicare Utilization:** 14

2021 Work RVU: 9.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 9.50 **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

34701 **Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 824

2021 Work RVU: 23.71
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.98

RUC Recommendation: 23.71 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34702 **Endovascular repair of infrarenal aorta by deployment of an aorto-aortic tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the aortic bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the aortic bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 99

2021 Work RVU: 36.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.51

RUC Recommendation: 36.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34703 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,118

2021 Work RVU: 26.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.34

RUC Recommendation: 26.52 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34704 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-uni-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 141

2021 Work RVU: 45.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.18

RUC Recommendation: 45.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34705 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 13,089

2021 Work RVU: 29.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.07

RUC Recommendation: 29.58 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34706 **Endovascular repair of infrarenal aorta and/or iliac artery(ies) by deployment of an aorto-bi-iliac endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, all endograft extension(s) placed in the aorta from the level of the renal arteries to the iliac bifurcation, and all angioplasty/stenting performed from the level of the renal arteries to the iliac bifurcation; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 641

2021 Work RVU: 45.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.45

RUC Recommendation: 45.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34707 **Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 652

2021 Work RVU: 22.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.55

RUC Recommendation: 22.28 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34708 **Endovascular repair of iliac artery by deployment of an ilio-iliac tube endograft including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally to the iliac bifurcation, and treatment zone angioplasty/stenting, when performed, unilateral; for rupture including temporary aortic and/or iliac balloon occlusion, when performed (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, traumatic disruption)**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 85

2021 Work RVU: 36.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.89

RUC Recommendation: 36.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34709 **Placement of extension prosthesis(es) distal to the common iliac artery(ies) or proximal to the renal artery(ies) for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, penetrating ulcer, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed, per vessel treated (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 3,632

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.40

RUC Recommendation: 6.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34710 **Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; initial vessel treated**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,186

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.80

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34711 **Delayed placement of distal or proximal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, dissection, endoleak, or endograft migration, including pre-procedure sizing and device selection, all nonselective catheterization(s), all associated radiological supervision and interpretation, and treatment zone angioplasty/stenting, when performed; each additional vessel treated (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 367

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.26

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34712 **Transcatheter delivery of enhanced fixation device(s) to the endograft (eg, anchor, screw, tack) and all associated radiological supervision and interpretation**

Global: 090 **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 1,214

2021 Work RVU: 12.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.47

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34713 **Percutaneous access and closure of femoral artery for delivery of endograft through a large sheath (12 french or larger), including ultrasound guidance, when performed, unilateral (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 16,159

2021 Work RVU: 2.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.53

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34714 **Open femoral artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by groin incision, unilateral (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 487

2021 Work RVU: 5.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.40

RUC Recommendation: 5.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34715 **Open axillary/subclavian artery exposure for delivery of endovascular prosthesis by infraclavicular or supraclavicular incision, unilateral (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 206

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.32

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34716 **Open axillary/subclavian artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by infraclavicular or supraclavicular incision, unilateral (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS, ACS **First Identified:** January 2017 **2019 est Medicare Utilization:** 798

2021 Work RVU: 7.19
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.00

RUC Recommendation: 7.19 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34800 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** AAOHNS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34802 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (1 docking limb)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis / Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34803 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (2 docking limbs)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34804 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34805 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-uniiliac or aorto-unifemoral prosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34806 **Transcatheter placement of wireless physiologic sensor in aneurysmal sac during endovascular repair, including radiological supervision and interpretation, instrument calibration, and collection of pressure data (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34812 **Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 9,013

2021 Work RVU: 4.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.90

RUC Recommendation: 4.13 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34820 **Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 82

2021 Work RVU: 7.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.44

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

34825 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; initial vessel**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Pre-Time Analysis / Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34826 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic or iliac aneurysm, false aneurysm, or dissection; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

34833 **Open iliac artery exposure with creation of conduit for delivery of endovascular prosthesis or for establishment of cardiopulmonary bypass, by abdominal or retroperitoneal incision, unilateral (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 46

2021 Work RVU: 8.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.29

RUC Recommendation: 8.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

34834 **Open brachial artery exposure for delivery of endovascular prosthesis, unilateral (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:** 366

2021 Work RVU: 2.65
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.48

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

34900 **Endovascular repair of iliac artery (eg, aneurysm, pseudoaneurysm, arteriovenous malformation, trauma) using ilio-iliac tube endoprosthesis**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35301 **Thromboendarterectomy, including patch graft, if performed; carotid, vertebral, subclavian, by neck incision**

Global: 090 **Issue:** Thromboendarterectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 21 **Specialty Developing Recommendation:** SVS **First Identified:** September 2011 **2019 est Medicare Utilization:** 35,904

2021 Work RVU: 21.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.69

RUC Recommendation: 21.16 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

35450 **Transluminal balloon angioplasty, open; renal or other visceral artery**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35452 **Transluminal balloon angioplasty, open; aortic**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35454 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35456 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35458 **Transluminal balloon angioplasty, open; brachiocephalic trunk or branches, each vessel**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35459 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35460 **Transluminal balloon angioplasty, open; venous**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35470 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35471 **Transluminal balloon angioplasty, percutaneous; renal or visceral artery**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35472 **Transluminal balloon angioplasty, percutaneous; aortic**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** Removed from CPT referral **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35473 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35474 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35475 **Transluminal balloon angioplasty, percutaneous; brachiocephalic trunk or branches, each vessel**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35476 **Transluminal balloon angioplasty, percutaneous; venous**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35490 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35491 **Deleted from CPT**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35492 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35493 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35494 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

35495 **Deleted from CPT** **Global:** **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35701 **Exploration not followed by surgical repair, artery; neck (eg, carotid, subclavian)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 823

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.08

RUC Recommendation: 7.50 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35702 **Exploration not followed by surgical repair, artery; upper extremity (eg, axillary, brachial, radial, ulnar)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 7.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.38

RUC Recommendation: 7.12 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35703 **Exploration not followed by surgical repair, artery; lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal)** **Global:** 090 **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.00

RUC Recommendation: 7.50 **Referred to CPT** September 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

35721 **Exploration (not followed by surgical repair), with or without lysis of artery; femoral artery** **Global:** **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 484

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

35741 **Exploration (not followed by surgical repair), with or without lysis of artery; popliteal artery**

Global: **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** January 2018 **2019 est Medicare Utilization:** 199

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

35761 **Exploration (not followed by surgical repair), with or without lysis of artery; other vessels**

Global: **Issue:** Exploration of Artery **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 06 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** April 2017 **2019 est Medicare Utilization:** 1,616

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36000 **Introduction of needle or intracatheter, vein**

Global: XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, AUR, AAP, AAFP, ACRh **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU: 0.18
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.07

RUC Recommendation: CMS consider a bundled status for this code **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36010 **Introduction of catheter, superior or inferior vena cava**

Global: XXX **Issue:** Introduction of Catheter **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,377

2021 Work RVU: 2.18
2021 NF PE RVU: 14.12
2021 Fac PE RVU: 0.62

RUC Recommendation: Remove from re-review. **Referred to CPT** February 2011 **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

36140 **Introduction of needle or intracatheter, upper or lower extremity artery**

Global: XXX **Issue:** Introduction of Needle or Intracatheter **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACRO **First Identified:** April 2011 **2019 est Medicare Utilization:** 20,331

2021 Work RVU: 1.76
2021 NF PE RVU: 13.35
2021 Fac PE RVU: 0.49

RUC Recommendation: Remove from re-review **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

36145 **Deleted from CPT**

Global: **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 9 **Specialty Developing Recommendation:** **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36147 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); initial access with complete radiological evaluation of dialysis access, including fluoroscopy, image documentation and report (includes access of shunt, injection[s] of contrast, and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36148 **Introduction of needle and/or catheter, arteriovenous shunt created for dialysis (graft/fistula); additional access for therapeutic intervention (List separately in addition to code for primary procedure)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36215 **Selective catheter placement, arterial system; each first order thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than $10 million / Harvard Valued - Utilization greater than 30,000-Part2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 45,269

2021 Work RVU: 4.17
2021 NF PE RVU: 28.04
2021 Fac PE RVU: 1.44

RUC Recommendation: 4.17 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36216 **Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,580

2021 Work RVU: 5.27
2021 NF PE RVU: 27.97
2021 Fac PE RVU: 1.66

RUC Recommendation: 5.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36217 **Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family**

Global: 000 **Issue:** Selective Catheter Placement **Screen:** Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 4,059

2021 Work RVU: 6.29
2021 NF PE RVU: 49.17
2021 Fac PE RVU: 1.98

RUC Recommendation: 6.29 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36218 **Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (list in addition to code for initial second or third order vessel as appropriate)**

Global: ZZZ **Issue:** Selective Catheter Placement **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 23 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,711

2021 Work RVU: 1.01
2021 NF PE RVU: 5.35
2021 Fac PE RVU: 0.30

RUC Recommendation: 1.01 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36221 **Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,095

2021 Work RVU: 3.92
2021 NF PE RVU: 27.05
2021 Fac PE RVU: 1.08

RUC Recommendation: 4.51 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36222 **Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral extracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 7,752

2021 Work RVU: 5.28
2021 NF PE RVU: 31.56
2021 Fac PE RVU: 1.77

RUC Recommendation: 6.00 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36223 **Selective catheter placement, common carotid or innominate artery, unilateral, any approach, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 29,312

2021 Work RVU: 5.75
2021 NF PE RVU: 42.78
2021 Fac PE RVU: 2.20

RUC Recommendation: 6.50 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36224 **Selective catheter placement, internal carotid artery, unilateral, with angiography of the ipsilateral intracranial carotid circulation and all associated radiological supervision and interpretation, includes angiography of the extracranial carotid and cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 36,594

2021 Work RVU: 6.25
2021 NF PE RVU: 55.63
2021 Fac PE RVU: 2.68

RUC Recommendation: 7.55 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36225 **Selective catheter placement, subclavian or innominate artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,267

2021 Work RVU: 5.75
2021 NF PE RVU: 40.17
2021 Fac PE RVU: 2.13

RUC Recommendation: 6.50 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36226 **Selective catheter placement, vertebral artery, unilateral, with angiography of the ipsilateral vertebral circulation and all associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed**

Global: 000 **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 32,221

2021 Work RVU: 6.25
2021 NF PE RVU: 52.87
2021 Fac PE RVU: 2.61

RUC Recommendation: 7.55 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36227 **Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 13,979

2021 Work RVU: 2.09
2021 NF PE RVU: 4.66
2021 Fac PE RVU: 0.83

RUC Recommendation: 2.32 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36228 **Selective catheter placement, each intracranial branch of the internal carotid or vertebral arteries, unilateral, with angiography of the selected vessel circulation and all associated radiological supervision and interpretation (eg, middle cerebral artery, posterior inferior cerebellar artery) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cervicocerebral Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 14 **Specialty Developing Recommendation:** AAN, AANS, ACC, ACR, ASN, CNS, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,336

2021 Work RVU: 4.25
2021 NF PE RVU: 34.39
2021 Fac PE RVU: 1.71

RUC Recommendation: 4.25 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36245 **Selective catheter placement, arterial system; each first order abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: XXX **Issue:** Selective Catheter Placement **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 22 **Specialty Developing Recommendation:** ACC, ACR, SIR, SCAI, SVS **First Identified:** October 2009 **2019 est Medicare Utilization:** 40,259

2021 Work RVU: 4.65
2021 NF PE RVU: 34.72
2021 Fac PE RVU: 1.43

RUC Recommendation: 4.90 **Referred to CPT** February 2010 and February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36246 **Selective catheter placement, arterial system; initial second order abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: 000 **Issue:** Vascular Injection Procedures **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 27 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 36,476

2021 Work RVU: 5.02
2021 NF PE RVU: 20.12
2021 Fac PE RVU: 1.35

RUC Recommendation: 5.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36247 **Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family**

Global: 000 **Issue:** Vascular Injection Procedures **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 27 **Specialty Developing Recommendation:** SVS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 66,061

2021 Work RVU: 6.04
2021 NF PE RVU: 38.48
2021 Fac PE RVU: 1.65

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

36248 **Selective catheter placement, arterial system; additional second order, third order, and beyond, abdominal, pelvic, or lower extremity artery branch, within a vascular family (list in addition to code for initial second or third order vessel as appropriate)**

Global: ZZZ **Issue:** Catheter Placement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:** 26,334

2021 Work RVU: 1.01
2021 NF PE RVU: 2.71
2021 Fac PE RVU: 0.28

RUC Recommendation: Remove from screen **Referred to CPT** February 2010 **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36251 **Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 3,603

2021 Work RVU: 5.10
2021 NF PE RVU: 35.66
2021 Fac PE RVU: 1.51

RUC Recommendation: 5.45 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36252 **Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 8,044

2021 Work RVU: 6.74
2021 NF PE RVU: 36.70
2021 Fac PE RVU: 2.26

RUC Recommendation: 7.38 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36253 **Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 1,646

2021 Work RVU: 7.30
2021 NF PE RVU: 57.15
2021 Fac PE RVU: 2.15

RUC Recommendation: 7.55 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36254 **Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral**

Global: 000 **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 11 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2011 **2019 est Medicare Utilization:** 162

2021 Work RVU: 7.90
2021 NF PE RVU: 54.59
2021 Fac PE RVU: 2.47

RUC Recommendation: 8.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36410 **Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)**

Global: XXX **Issue:** Venipunture **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 36 **Specialty Developing Recommendation:** ACP **First Identified:** October 2009 **2019 est Medicare Utilization:** 155,240

2021 Work RVU: 0.18
2021 NF PE RVU: 0.31
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

36475 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated**

Global: 000 **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 109,583

2021 Work RVU: 5.30
2021 NF PE RVU: 31.36
2021 Fac PE RVU: 1.73

RUC Recommendation: 5.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36476 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** October 2013 **2019 est Medicare Utilization:** 7,170

2021 Work RVU: 2.65
2021 NF PE RVU: 5.77
2021 Fac PE RVU: 0.72

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36478 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated**

Global: 000 **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,677

2021 Work RVU: 5.30
2021 NF PE RVU: 25.42
2021 Fac PE RVU: 1.76

RUC Recommendation: 5.30 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36479 **Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovenous Ablation **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 38 **Specialty Developing Recommendation:** ACC, ACR, ACS, SCAI, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,461

2021 Work RVU: 2.65
2021 NF PE RVU: 6.26
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36481 **Percutaneous portal vein catheterization by any method**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 697

2021 Work RVU: 6.73
2021 NF PE RVU: 49.03
2021 Fac PE RVU: 2.06

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

36511 **Therapeutic apheresis; for white blood cells**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 235

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.06

RUC Recommendation: 2.00. Refer to CPT Assistant. **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36512 **Therapeutic apheresis; for red blood cells**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 2,896

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.00. Refer to CPT Assistant. **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36513 **Therapeutic apheresis; for platelets**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 192

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.94

RUC Recommendation: 2.00. Refer to CPT Assistant. **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

Status Report: CMS Requests and Relativity Assessment Issues

36514 **Therapeutic apheresis; for plasma pheresis**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 28,894

2021 Work RVU: 1.81
2021 NF PE RVU: 17.01
2021 Fac PE RVU: 0.79

RUC Recommendation: 1.81. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36515 **Therapeutic apheresis; with extracorporeal immunoadsorption and plasma reinfusion**

Global: **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36516 **Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion**

Global: 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,069

2021 Work RVU: 1.56
2021 NF PE RVU: 56.69
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.56. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2009

Status Report: CMS Requests and Relativity Assessment Issues

36522 **Photopheresis, extracorporeal** **Global:** 000 **Issue:** Therapeutic Apheresis **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 12 **Specialty Developing Recommendation:** CAP, RPA **First Identified:** January 2017 **2019 est Medicare Utilization:** 8,303

2021 Work RVU: 1.75
2021 NF PE RVU: 48.78
2021 Fac PE RVU: 0.97

RUC Recommendation: 1.75. Refer to CPT Assistant **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2018

36555 **Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age** **Global:** 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 26

2021 Work RVU: 1.93
2021 NF PE RVU: 3.70
2021 Fac PE RVU: 0.37

RUC Recommendation: 1.93 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36556 **Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older** **Global:** 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 409,595

2021 Work RVU: 1.75
2021 NF PE RVU: 4.60
2021 Fac PE RVU: 0.50

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36568 **Insertion of peripherally inserted central venous catheter (picc), without subcutaneous port or pump, without imaging guidance; younger than 5 years of age**

Global: 000 **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2016 **2019 est Medicare Utilization:** 3

2021 Work RVU: 2.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.34

RUC Recommendation: 2.11 **Referred to CPT** September 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36569 **Insertion of peripherally inserted central venous catheter (picc), without subcutaneous port or pump, without imaging guidance; age 5 years or older**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** July 2015 **2019 est Medicare Utilization:** 14,961

2021 Work RVU: 1.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.61

RUC Recommendation: 1.90. Review at RAW in October 2021. **Referred to CPT** September 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36572 **Insertion of peripherally inserted central venous catheter (picc), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 25

2021 Work RVU: 1.82
2021 NF PE RVU: 11.35
2021 Fac PE RVU: 0.65

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36573 **Insertion of peripherally inserted central venous catheter (picc), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older**

Global: 000 **Issue:** PICC Line Procedures **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:**

First Identified: September 2017 **2019 est Medicare Utilization:** 88,728

2021 Work RVU: 1.70
2021 NF PE RVU: 10.27
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36584 **Replacement, complete, of a peripherally inserted central venous catheter (picc), without subcutaneous port or pump, through same venous access, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the replacement**

Global: 000 **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2016 **2019 est Medicare Utilization:** 4,270

2021 Work RVU: 1.20
2021 NF PE RVU: 9.21
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.47 **Referred to CPT** September 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36620 **Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous**

Global: 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 / Codes Reported Together 75%or More-Part4 / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACR, ASA

First Identified: July 2015 **2019 est Medicare Utilization:** 581,132

2021 Work RVU: 1.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.20

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36818 **Arteriovenous anastomosis, open; by upper arm cephalic vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 5,179

2021 Work RVU: 12.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.81

RUC Recommendation: 13.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

36819 **Arteriovenous anastomosis, open; by upper arm basilic vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 7,456

2021 Work RVU: 13.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.87

RUC Recommendation: 15.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

36820 **Arteriovenous anastomosis, open; by forearm vein transposition** **Global:** 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,343

2021 Work RVU: 13.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.90

RUC Recommendation: 13.99 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36821 **Arteriovenous anastomosis, open; direct, any site (eg, cimino type) (separate procedure)**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 30,775

2021 Work RVU: 11.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.61

RUC Recommendation: 11.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36822 **Insertion of cannula(s) for prolonged extracorporeal circulation for cardiopulmonary insufficiency (ECMO) (separate procedure)**

Global: **Issue:** ECMO-ECLS **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 11 **Specialty Developing Recommendation:** STS, AAP, ACC, SCAI **First Identified:** February 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36825 **Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** Site of Service Anomaly / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,949

2021 Work RVU: 14.17
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.66

RUC Recommendation: 15.93 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36830 **Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); nonautogenous graft (eg, biological collagen, thermoplastic graft)**

Global: 090 **Issue:** Arteriovenous Anastomosis **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 10 **Specialty Developing Recommendation:** ACS, SVS **First Identified:** November 2012 **2019 est Medicare Utilization:** 20,101

2021 Work RVU: 12.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.56

RUC Recommendation: 11.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36834 **Deleted from CPT**

Global: **Issue:** Aneurysm Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AVA, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

36870 **Thrombectomy, percutaneous, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis)**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36901 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report;**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 68,183

2021 Work RVU: 3.36
2021 NF PE RVU: 17.84
2021 Fac PE RVU: 1.05

RUC Recommendation: 3.36 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36902 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 199,617

2021 Work RVU: 4.83
2021 NF PE RVU: 33.47
2021 Fac PE RVU: 1.47

RUC Recommendation: 4.83 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36903 **Introduction of needle(s) and/or catheter(s), dialysis circuit, with diagnostic angiography of the dialysis circuit, including all direct puncture(s) and catheter placement(s), injection(s) of contrast, all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava, fluoroscopic guidance, radiological supervision and interpretation and image documentation and report; with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis segment**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 20,847

2021 Work RVU: 6.39
2021 NF PE RVU: 140.30
2021 Fac PE RVU: 1.82

RUC Recommendation: 6.39 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

36904 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s);**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 4,595

2021 Work RVU: 7.50
2021 NF PE RVU: 48.72
2021 Fac PE RVU: 2.16

RUC Recommendation: 7.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36905 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transluminal balloon angioplasty, peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 41,205

2021 Work RVU: 9.00
2021 NF PE RVU: 63.02
2021 Fac PE RVU: 2.73

RUC Recommendation: 9.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36906 **Percutaneous transluminal mechanical thrombectomy and/or infusion for thrombolysis, dialysis circuit, any method, including all imaging and radiological supervision and interpretation, diagnostic angiography, fluoroscopic guidance, catheter placement(s), and intraprocedural pharmacological thrombolytic injection(s); with transcatheter placement of intravascular stent(s), peripheral dialysis segment, including all imaging and radiological supervision and interpretation necessary to perform the stenting, and all angioplasty within the peripheral dialysis circuit**

Global: 000 **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 14,028

2021 Work RVU: 10.42
2021 NF PE RVU: 173.18
2021 Fac PE RVU: 3.02

RUC Recommendation: 10.42 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36907 **Transluminal balloon angioplasty, central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the angioplasty (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 67,888

2021 Work RVU: 3.00
2021 NF PE RVU: 16.34
2021 Fac PE RVU: 0.83

RUC Recommendation: 3.00 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

36908 **Transcatheter placement of intravascular stent(s), central dialysis segment, performed through dialysis circuit, including all imaging and radiological supervision and interpretation required to perform the stenting, and all angioplasty in the central dialysis segment (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,376

2021 Work RVU: 4.25
2021 NF PE RVU: 49.50
2021 Fac PE RVU: 1.13

RUC Recommendation: 4.25 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

36909 **Dialysis circuit permanent vascular embolization or occlusion (including main circuit or any accessory veins), endovascular, including all imaging and radiological supervision and interpretation necessary to complete the intervention (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 5,424

2021 Work RVU: 4.12
2021 NF PE RVU: 57.02
2021 Fac PE RVU: 1.11

RUC Recommendation: 4.12 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37183 **Revision of transvenous intrahepatic portosystemic shunt(s) (tips) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recannulization/dilatation, stent placement and all associated imaging guidance and documentation)**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 893

2021 Work RVU: 7.74
2021 NF PE RVU: 180.49
2021 Fac PE RVU: 2.36

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37191 **Insertion of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 25,555

2021 Work RVU: 4.46
2021 NF PE RVU: 63.97
2021 Fac PE RVU: 1.38

RUC Recommendation: 4.71 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37192 **Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 32

2021 Work RVU: 7.10
2021 NF PE RVU: 31.60
2021 Fac PE RVU: 1.20

RUC Recommendation: 8.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37193 **Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed**

Global: 000 **Issue:** IVC Transcatheter Procedure **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2011 **2019 est Medicare Utilization:** 7,478

2021 Work RVU: 7.10
2021 NF PE RVU: 39.56
2021 Fac PE RVU: 2.01

RUC Recommendation: 8.00 **Referred to CPT** February 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37201 **Transcatheter therapy, infusion for thrombolysis other than coronary**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37203 **Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter)**

Global: **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 07 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37204 **Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck**

Global: **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37205 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; initial vessel**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37206 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity arteries), percutaneous; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37207 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; initial vessel**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37208 **Transcatheter placement of an intravascular stent(s) (except coronary, carotid, vertebral, iliac and lower extremity arteries), open; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 07 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37209 **Exchange of a previously placed intravascular catheter during thrombolytic therapy**

Global: **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

37210 **Uterine fibroid embolization (UFE, embolization of the uterine arteries to treat uterine fibroids, leiomyomata), percutaneous approach inclusive of vascular access, vessel selection, embolization, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the procedure**

Global: **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37211 **Transcatheter therapy, arterial infusion for thrombolysis other than coronary or intracranial, any method, including radiological supervision and interpretation, initial treatment day**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,642

2021 Work RVU: 7.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.10

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37212 **Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,012

2021 Work RVU: 6.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.89

RUC Recommendation: 7.06 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37213 **Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed;**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,217

2021 Work RVU: 4.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.25

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37214 **Transcatheter therapy, arterial or venous infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, continued treatment on subsequent day during course of thrombolytic therapy, including follow-up catheter contrast injection, position change, or exchange, when performed; cessation of thrombolysis including removal of catheter and vessel closure by any method**

Global: 000 **Issue:** Bundle Thrombolysis **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,963

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.66

RUC Recommendation: 3.04 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37220 **Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 12,377

2021 Work RVU: 7.90
2021 NF PE RVU: 74.19
2021 Fac PE RVU: 2.01

RUC Recommendation: Refer to CPT. 8.15 **Referred to CPT** February 2022 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37221 **Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 35,798

2021 Work RVU: 9.75
2021 NF PE RVU: 96.83
2021 Fac PE RVU: 2.50

RUC Recommendation: Refer to CPT. 10.00 **Referred to CPT** February 2022 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37222 **Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,550

2021 Work RVU: 3.73
2021 NF PE RVU: 16.14
2021 Fac PE RVU: 0.84

RUC Recommendation: Refer to CPT. 3.73 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37223 **Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,293

2021 Work RVU: 4.25
2021 NF PE RVU: 44.04
2021 Fac PE RVU: 1.00

RUC Recommendation: Refer to CPT. 4.25 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37224 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 34,142

2021 Work RVU: 8.75
2021 NF PE RVU: 88.47
2021 Fac PE RVU: 2.29

RUC Recommendation: Refer to CPT. 9.00 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37225 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 45,496

2021 Work RVU: 11.75
2021 NF PE RVU: 299.74
2021 Fac PE RVU: 3.24

RUC Recommendation: Refer to CPT. **Referred to CPT** February 2022 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37226 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 24,981

2021 Work RVU: 10.24
2021 NF PE RVU: 273.20
2021 Fac PE RVU: 2.63

RUC Recommendation: Refer to CPT. 10.49 **Referred to CPT** February 2022 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37227 **Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 23,176

2021 Work RVU: 14.25
2021 NF PE RVU: 385.21
2021 Fac PE RVU: 3.70

RUC Recommendation: Refer to CPT. 14.50 **Referred to CPT** February 2022 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37228 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 34,531

2021 Work RVU: 10.75
2021 NF PE RVU: 128.91
2021 Fac PE RVU: 2.71

RUC Recommendation: Refer to CPT. 11.00 **Referred to CPT** February 2022 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37229 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 / PE Screen - High Cost Supplies / High Volume Growth5 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 39,373

2021 Work RVU: 13.80
2021 NF PE RVU: 299.25
2021 Fac PE RVU: 3.68

RUC Recommendation: Refer to CPT. 14.05 **Referred to CPT** February 2022 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37230 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,808

2021 Work RVU: 13.55
2021 NF PE RVU: 284.04
2021 Fac PE RVU: 3.81

RUC Recommendation: Refer to CPT. 13.80 **Referred to CPT** February 2022 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37231 **Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**

Global: 000 **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,320

2021 Work RVU: 14.75
2021 NF PE RVU: 386.13
2021 Fac PE RVU: 4.12

RUC Recommendation: Refer to CPT. 15.00 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37232 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,835

2021 Work RVU: 4.00
2021 NF PE RVU: 23.55
2021 Fac PE RVU: 1.01

RUC Recommendation: Refer to CPT. 4.00 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37233 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,241

2021 Work RVU: 6.50
2021 NF PE RVU: 27.13
2021 Fac PE RVU: 1.62

RUC Recommendation: Refer to CPT. 6.50 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37234 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 343

2021 Work RVU: 5.50
2021 NF PE RVU: 111.73
2021 Fac PE RVU: 1.62

RUC Recommendation: Refer to CPT. 5.50 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37235 **Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Endovascular Revascularization **Screen:** High Volume Growth1 **Complete?** No

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 100

2021 Work RVU: 7.80
2021 NF PE RVU: 116.61
2021 Fac PE RVU: 2.24

RUC Recommendation: Refer to CPT. 7.80 **Referred to CPT** February 2022 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37236 **Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; initial artery**

Global: 000 **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 13,074

2021 Work RVU: 8.75
2021 NF PE RVU: 84.52
2021 Fac PE RVU: 2.32

RUC Recommendation: 9.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37237 **Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 1,497

2021 Work RVU: 4.25
2021 NF PE RVU: 43.32
2021 Fac PE RVU: 0.98

RUC Recommendation: 4.25 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37238 **Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein**

Global: 000 **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 10,579

2021 Work RVU: 6.04
2021 NF PE RVU: 106.77
2021 Fac PE RVU: 1.72

RUC Recommendation: 6.29 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37239 **Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Transcatheter Placement of Intravascular Stent **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 09 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2013 **2019 est Medicare Utilization:** 4,688

2021 Work RVU: 2.97
2021 NF PE RVU: 53.45
2021 Fac PE RVU: 0.83

RUC Recommendation: 3.34 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37241 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,922

2021 Work RVU: 8.75
2021 NF PE RVU: 137.81
2021 Fac PE RVU: 2.50

RUC Recommendation: 9.00 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37242 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 8,635

2021 Work RVU: 9.80
2021 NF PE RVU: 220.06
2021 Fac PE RVU: 2.58

RUC Recommendation: 11.98 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37243 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,067

2021 Work RVU: 11.74
2021 NF PE RVU: 271.90
2021 Fac PE RVU: 3.36

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37244 **Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation**

Global: 000 **Issue:** Embolization and Occlusion Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 08 **Specialty Developing Recommendation:** SVS, ACS, SIR, ACR, ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 12,731

2021 Work RVU: 13.75
2021 NF PE RVU: 198.34
2021 Fac PE RVU: 4.14

RUC Recommendation: 14.00 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37246 **Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery**

Global: 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 8,680

2021 Work RVU: 7.00
2021 NF PE RVU: 51.34
2021 Fac PE RVU: 1.87

RUC Recommendation: 7.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37247 **Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; each additional artery (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 760

2021 Work RVU: 3.50
2021 NF PE RVU: 14.34
2021 Fac PE RVU: 0.73

RUC Recommendation: 3.50 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37248 **Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; initial vein**

Global: 000 **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 15,577

2021 Work RVU: 6.00
2021 NF PE RVU: 37.31
2021 Fac PE RVU: 1.79

RUC Recommendation: 6.00 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37249 **Transluminal balloon angioplasty (except dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same vein; each additional vein (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2015 **2019 est Medicare Utilization:** 3,865

2021 Work RVU: 2.97
2021 NF PE RVU: 11.33
2021 Fac PE RVU: 0.76

RUC Recommendation: 2.97 **Referred to CPT** October 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

37250 **Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37251 **Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

37252 **Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 / Work Neutrality (CPT 2016) **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 14 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:** 60,377

2021 Work RVU: 1.80
2021 NF PE RVU: 30.84
2021 Fac PE RVU: 0.45

RUC Recommendation: 1.80 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37253 **Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 / Work Neutrality (CPT 2016) **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 14 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:** 91,408

2021 Work RVU: 1.44
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 0.36

RUC Recommendation: 1.44 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37609 **Ligation or biopsy, temporal artery**

Global: 010 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** SVS, ACS

First Identified: September 2007 **2019 est Medicare Utilization:** 14,539

2021 Work RVU: 3.05
2021 NF PE RVU: 5.75
2021 Fac PE RVU: 2.33

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

37619 **Ligation of inferior vena cava**

Global: 090 **Issue:** Ligation of Inferior Vena Cava **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACS, SVS

First Identified: February 2011 **2019 est Medicare Utilization:** 33

2021 Work RVU: 30.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.67

RUC Recommendation: 37.60

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

37620 **Interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device)**

Global: **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACR, SIR, SVS

First Identified: February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

37760 **Ligation of perforator veins, subfascial, radical (linton type), including skin graft, when performed, open,1 leg**

Global: 090 **Issue:** Perorator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 10 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 65

2021 Work RVU: 10.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.01

RUC Recommendation: 10.69 **Referred to CPT** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

37761 **Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg**

Global: 090 **Issue:** Perforator Vein Ligation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 10 **Specialty Developing Recommendation:** SVS, ACS **First Identified:** April 2009 **2019 est Medicare Utilization:** 350

2021 Work RVU: 9.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.43

RUC Recommendation: 9.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

37765 **Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions**

Global: 010 **Issue:** Stab Phlebectomy of Varicose Veins **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACS, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:** 14,709

2021 Work RVU: 4.80
2021 NF PE RVU: 7.22
2021 Fac PE RVU: 2.08

RUC Recommendation: 4.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

37766 **Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions**

Global: 010 **Issue:** Stab Phlebectomy of Varicose Veins **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACS, SIR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:** 11,253

2021 Work RVU: 6.00
2021 NF PE RVU: 7.92
2021 Fac PE RVU: 2.42

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

37785 **Ligation, division, and/or excision of varicose vein cluster(s), 1 leg**

Global: 090 **Issue:** Ligation **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** APMA, SVS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 934

2021 Work RVU: 3.93
2021 NF PE RVU: 5.80
2021 Fac PE RVU: 2.69

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

38220 **Diagnostic bone marrow; aspiration(s)**

Global: XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** February 2016 **2019 est Medicare Utilization:** 7,044

2021 Work RVU: 1.20
2021 NF PE RVU: 3.57
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.20 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

38221 **Diagnostic bone marrow; biopsy(ies)**

Global: XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** July 2015 **2019 est Medicare Utilization:** 12,465

2021 Work RVU: 1.28
2021 NF PE RVU: 3.37
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.28 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

38222 **Diagnostic bone marrow; biopsy(ies) and aspiration(s)**

Global: XXX **Issue:** Diagnostic Bone Marrow Aspiration and Biopsy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 06 **Specialty Developing Recommendation:** ASCO, ASH, CAP ASBMT **First Identified:** February 2016 **2019 est Medicare Utilization:** 120,998

2021 Work RVU: 1.44
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 0.69

RUC Recommendation: 1.44 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

38505 **Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)**

Global: 000 **Issue:** Needle Biopsy of Lymph Nodes **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2019 **2019 est Medicare Utilization:** 33,584

2021 Work RVU: 1.14
2021 NF PE RVU: 2.36
2021 Fac PE RVU: 0.77

RUC Recommendation: 1.59 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

38542 **Dissection, deep jugular node(s)**

Global: 090 **Issue:** Jugular Node Dissection **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 40 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 571

2021 Work RVU: 7.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.90

RUC Recommendation: 7.85 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

38570 **Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple**

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 12 **Specialty Developing Recommendation:** AUA **First Identified:** January 2014 **2019 est Medicare Utilization:** 5,714

2021 Work RVU: 8.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.18

RUC Recommendation: 9.34 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

38571 **Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy**

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** CMS Fastest Growing / 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 12 **Specialty Developing Recommendation:** AUA **First Identified:** October 2008 **2019 est Medicare Utilization:** 17,981

2021 Work RVU: 12.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.87

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

38572 **Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple**

Global: 010 **Issue:** Laparoscopy Lymphadenectomy **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 12 **Specialty Developing Recommendation:** ACOG **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,251

2021 Work RVU: 15.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.67

RUC Recommendation: 15.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

38792 **Injection procedure; radioactive tracer for identification of sentinel node**

Global: 000 **Issue:** Radioactive Tracer **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 23 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 33,143

2021 Work RVU: 0.65
2021 NF PE RVU: 1.72
2021 Fac PE RVU: 0.23

RUC Recommendation: 0.65 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

39400 **Mediastinoscopy, includes biopsy(ies), when performed**

Global: **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 08 **Specialty Developing Recommendation:** STS **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

39401 **Mediastinoscopy; includes biopsy(ies) of mediastinal mass (eg, lymphoma), when performed**

Global: 000 **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 08 **Specialty Developing Recommendation:** STS **First Identified:** October 2014 **2019 est Medicare Utilization:** 535

2021 Work RVU: 5.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.30

RUC Recommendation: 5.44 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

39402 **Mediastinoscopy; with lymph node biopsy(ies) (eg, lung cancer staging)**

Global: 000 **Issue:** Mediastinoscopy with Biopsy **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 08 **Specialty Developing Recommendation:** STS **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,086

2021 Work RVU: 7.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.87

RUC Recommendation: 7.50 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

40490 **Biopsy of lip**

Global: 000 **Issue:** Biopsy of Lip **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 21 **Specialty Developing Recommendation:** AAO-HNS, AAD **First Identified:** April 2011 **2019 est Medicare Utilization:** 32,762

2021 Work RVU: 1.22
2021 NF PE RVU: 2.34
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

40650 **Repair lip, full thickness; vermilion only**

Global: 090 **Issue:** PE Subcommittee **Screen:** Emergent Procedures **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 46 **Specialty Developing Recommendation:** AAOS, ACEP, and orthopaedic subspecialties **First Identified:** October 2015 **2019 est Medicare Utilization:** 355

2021 Work RVU: 3.78
2021 NF PE RVU: 9.72
2021 Fac PE RVU: 4.60

RUC Recommendation: PE Clinical staff pre-time revised **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2016

Status Report: CMS Requests and Relativity Assessment Issues

40800 **Drainage of abscess, cyst, hematoma, vestibule of mouth; simple** **Global:** 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,390

2021 Work RVU: 1.23
2021 NF PE RVU: 4.87
2021 Fac PE RVU: 2.19

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

40801 **Drainage of abscess, cyst, hematoma, vestibule of mouth; complicated** **Global:** 010 **Issue:** Ostectomy **Screen:** Site of Service Anomaly (99238-Only) / 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** APMA, AAOS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,609

2021 Work RVU: 2.63
2021 NF PE RVU: 5.88
2021 Fac PE RVU: 2.97

RUC Recommendation: Maintain. Reduced 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

40808 **Biopsy, vestibule of mouth** **Global:** 010 **Issue:** Biopsy of Mouth Lesion **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAOHNS, AAOMS **First Identified:** April 2017 **2019 est Medicare Utilization:** 10,517

2021 Work RVU: 1.05
2021 NF PE RVU: 3.81
2021 Fac PE RVU: 1.36

RUC Recommendation: 1.05 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

40812 **Excision of lesion of mucosa and submucosa, vestibule of mouth; with simple repair**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 5,703

2021 Work RVU: 2.37
2021 NF PE RVU: 5.96
2021 Fac PE RVU: 2.85

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

40820 **Destruction of lesion or scar of vestibule of mouth by physical methods (eg, laser, thermal, cryo, chemical)**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,264

2021 Work RVU: 1.34
2021 NF PE RVU: 6.47
2021 Fac PE RVU: 3.54

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

41530 **Submucosal ablation of the tongue base, radiofrequency, 1 or more sites, per session**

Global: 000 **Issue:** Submucosal ablation of tongue base **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 26 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** July 2014 **2019 est Medicare Utilization:** 350

2021 Work RVU: 3.50
2021 NF PE RVU: 25.25
2021 Fac PE RVU: 7.42

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

42145 **Palatopharyngoplasty (eg, uvulopalatopharyngoplasty, uvulopharyngoplasty)**

Global: 090 **Issue:** Palatopharyngoplasty **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 41 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 518

2021 Work RVU: 9.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.13

RUC Recommendation: 9.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

42415 **Excision of parotid tumor or parotid gland; lateral lobe, with dissection and preservation of facial nerve**

Global: 090 **Issue:** Excise Parotid Gland/Lesion **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 27 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,439

2021 Work RVU: 17.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.16

RUC Recommendation: 18.12 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

42420 **Excision of parotid tumor or parotid gland; total, with dissection and preservation of facial nerve**

Global: 090 **Issue:** Excise Parotid Gland/Lesion **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 27 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,561

2021 Work RVU: 19.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.21

RUC Recommendation: 21.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

42440 **Excision of submandibular (submaxillary) gland**

Global: 090 **Issue:** Submandibular Gland Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 64 **Specialty Developing Recommendation:** AAO-HNS, ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,780

2021 Work RVU: 6.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.06

RUC Recommendation: 7.13 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43191 **Esophagoscopy, rigid, transoral; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,988

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.65

RUC Recommendation: 2.78 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43192 **Esophagoscopy, rigid, transoral; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 211

2021 Work RVU: 2.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.21 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43193 **Esophagoscopy, rigid, transoral; with biopsy, single or multiple**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 210

2021 Work RVU: 2.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.72

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43194 **Esophagoscopy, rigid, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 115

2021 Work RVU: 3.51
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.55

RUC Recommendation: 3.99 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43195 **Esophagoscopy, rigid, transoral; with balloon dilation (less than 30 mm diameter)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 569

2021 Work RVU: 3.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.21 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43196 **Esophagoscopy, rigid, transoral; with insertion of guide wire followed by dilation over guide wire**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 486

2021 Work RVU: 3.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.94

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

43197 **Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES, AGA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,136

2021 Work RVU: 1.52
2021 NF PE RVU: 4.07
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.59 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43198 **Esophagoscopy, flexible, transnasal; with biopsy, single or multiple**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, ASGE, SAGES, AGA **First Identified:** September 2011 **2019 est Medicare Utilization:** 255

2021 Work RVU: 1.82
2021 NF PE RVU: 4.32
2021 Fac PE RVU: 0.79

RUC Recommendation: 1.89 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43200 **Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 5,390

2021 Work RVU: 1.42
2021 NF PE RVU: 6.21
2021 Fac PE RVU: 0.92

RUC Recommendation: 1.59 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43201 **Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 220

2021 Work RVU: 1.72
2021 NF PE RVU: 5.78
2021 Fac PE RVU: 1.04

RUC Recommendation: 1.90 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43202 **Esophagoscopy, flexible, transoral; with biopsy, single or multiple**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,578

2021 Work RVU: 1.72
2021 NF PE RVU: 8.94
2021 Fac PE RVU: 1.05

RUC Recommendation: 1.89 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43204 **Esophagoscopy, flexible, transoral; with injection sclerosis of esophageal varices**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 13

2021 Work RVU: 2.33
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.35

RUC Recommendation: 2.89 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43205 **Esophagoscopy, flexible, transoral; with band ligation of esophageal varices**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 159

2021 Work RVU: 2.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.40

RUC Recommendation: 3.00 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43206 **Esophagoscopy, flexible, transoral; with optical endomicroscopy** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 21

2021 Work RVU: 2.29
2021 NF PE RVU: 6.52
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43211 **Esophagoscopy, flexible, transoral; with endoscopic mucosal resection** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 99

2021 Work RVU: 4.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.17

RUC Recommendation: 4.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43212 **Esophagoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 585

2021 Work RVU: 3.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.57

RUC Recommendation: 3.73 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43213 **Esophagoscopy, flexible, transoral; with dilation of esophagus, by balloon or dilator, retrograde (includes fluoroscopic guidance, when performed)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 187

2021 Work RVU: 4.63
2021 NF PE RVU: 33.35
2021 Fac PE RVU: 2.24

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43214 **Esophagoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 215

2021 Work RVU: 3.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.78

RUC Recommendation: 3.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43215 **Esophagoscopy, flexible, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 989

2021 Work RVU: 2.44
2021 NF PE RVU: 9.30
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.60 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43216 **Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 195

2021 Work RVU: 2.30
2021 NF PE RVU: 10.01
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.40 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43217 **Esophagoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 53

2021 Work RVU: 2.80
2021 NF PE RVU: 9.72
2021 Fac PE RVU: 1.56

RUC Recommendation: 2.90 **Referred to CPT** May 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43219 **Esophagoscopy, rigid or flexible; with insertion of plastic tube or stent** **Global:** **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43220 **Esophagoscopy, flexible, transoral; with transendoscopic balloon dilation (less than 30 mm diameter)** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,069

2021 Work RVU: 2.00
2021 NF PE RVU: 27.96
2021 Fac PE RVU: 1.18

RUC Recommendation: 2.10 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43226 **Esophagoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) over guide wire** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AAO-HNS, AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,841

2021 Work RVU: 2.24
2021 NF PE RVU: 8.98
2021 Fac PE RVU: 1.23

RUC Recommendation: 2.34 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43227 **Esophagoscopy, flexible, transoral; with control of bleeding, any method** **Global:** 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 191

2021 Work RVU: 2.89
2021 NF PE RVU: 15.89
2021 Fac PE RVU: 1.58

RUC Recommendation: 3.26 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43228 **Esophagoscopy, rigid or flexible; with ablation of tumor(s), polyp(s), or other lesion(s), not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43229 **Esophagoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,331

2021 Work RVU: 3.49
2021 NF PE RVU: 18.25
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.72 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43231 **Esophagoscopy, flexible, transoral; with endoscopic ultrasound examination**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 502

2021 Work RVU: 2.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.55

RUC Recommendation: 3.19 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43232 **Esophagoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s)**

Global: 000 **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 435

2021 Work RVU: 3.59
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.83 **Referred to CPT** May 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43233 **Esophagogastroduodenoscopy, flexible, transoral; with dilation of esophagus with balloon (30 mm diameter or larger) (includes fluoroscopic guidance, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,577

2021 Work RVU: 4.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.03

RUC Recommendation: 4.45 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43234 **Upper gastrointestinal endoscopy, simple primary examination (eg, with small diameter flexible endoscope) (separate procedure)**

Global: **Issue:** Esophagoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43235 **Esophagogastroduodenoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** EGD **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 323,621

2021 Work RVU: 2.09
2021 NF PE RVU: 6.59
2021 Fac PE RVU: 1.23

RUC Recommendation: 2.26 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43236 **Esophagogastroduodenoscopy, flexible, transoral; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2008 **2019 est Medicare Utilization:** 16,281

2021 Work RVU: 2.39
2021 NF PE RVU: 9.43
2021 Fac PE RVU: 1.37

RUC Recommendation: 2.57 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Apr 2009 and Jun 2010

43237 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 18,922

2021 Work RVU: 3.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.85

RUC Recommendation: 3.85 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43238 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), (includes endoscopic ultrasound examination limited to the esophagus, stomach or duodenum, and adjacent structures)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 14,141

2021 Work RVU: 4.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.15

RUC Recommendation: 4.50 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43239 **Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple**

Global: 000 **Issue:** EGD with Biopsy **Screen:** MPC List / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,424,058

2021 Work RVU: 2.39
2021 NF PE RVU: 8.84
2021 Fac PE RVU: 1.37

RUC Recommendation: 2.39 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43240 **Esophagogastroduodenoscopy, flexible, transoral; with transmural drainage of pseudocyst (includes placement of transmural drainage catheter[s]/stent[s], when performed, and endoscopic ultrasound, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,002

2021 Work RVU: 7.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.48

RUC Recommendation: 7.25 **Referred to CPT** February 2013 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

43241 **Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,312

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.36

RUC Recommendation: 2.59 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43242 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** October 2008 **2019 est Medicare Utilization:** 26,340

2021 Work RVU: 4.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.41

RUC Recommendation: 5.39 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

43243 **Esophagogastroduodenoscopy, flexible, transoral; with injection sclerosis of esophageal/gastric varices**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 647

2021 Work RVU: 4.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.14

RUC Recommendation: 4.37 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43244 **Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 22,233

2021 Work RVU: 4.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.26

RUC Recommendation: 4.50 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43245 **Esophagogastroduodenoscopy, flexible, transoral; with dilation of gastric/duodenal stricture(s) (eg, balloon, bougie)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 15,047

2021 Work RVU: 3.08
2021 NF PE RVU: 15.04
2021 Fac PE RVU: 1.64

RUC Recommendation: 3.18 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43246 **Esophagogastroduodenoscopy, flexible, transoral; with directed placement of percutaneous gastrostomy tube**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 71,081

2021 Work RVU: 3.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.78

RUC Recommendation: 4.32 **Referred to CPT** October 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

43247 **Esophagogastroduodenoscopy, flexible, transoral; with removal of foreign body(s)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 28,637

2021 Work RVU: 3.11
2021 NF PE RVU: 8.12
2021 Fac PE RVU: 1.67

RUC Recommendation: 3.27 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43248 **Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 110,879

2021 Work RVU: 2.91
2021 NF PE RVU: 9.18
2021 Fac PE RVU: 1.60

RUC Recommendation: 3.01 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43249 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic balloon dilation of esophagus (less than 30 mm diameter)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 125,878

2021 Work RVU: 2.67
2021 NF PE RVU: 31.47
2021 Fac PE RVU: 1.49

RUC Recommendation: 2.77 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43250 **Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,775

2021 Work RVU: 2.97
2021 NF PE RVU: 10.44
2021 Fac PE RVU: 1.58

RUC Recommendation: 3.07 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43251 **Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 35,888

2021 Work RVU: 3.47
2021 NF PE RVU: 11.28
2021 Fac PE RVU: 1.84

RUC Recommendation: 3.57 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43253 **Esophagogastroduodenoscopy, flexible, transoral; with transendoscopic ultrasound-guided transmural injection of diagnostic or therapeutic substance(s) (eg, anesthetic, neurolytic agent) or fiducial marker(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** February 2012 **2019 est Medicare Utilization:** 2,309

2021 Work RVU: 4.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.41

RUC Recommendation: 5.39 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43254 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic mucosal resection**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,797

2021 Work RVU: 4.87
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.46

RUC Recommendation: 5.25 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43255 **Esophagogastroduodenoscopy, flexible, transoral; with control of bleeding, any method**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 62,091

2021 Work RVU: 3.56
2021 NF PE RVU: 16.12
2021 Fac PE RVU: 1.88

RUC Recommendation: 4.20 **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43256 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43257 **Esophagogastroduodenoscopy, flexible, transoral; with delivery of thermal energy to the muscle of lower esophageal sphincter and/or gastric cardia, for treatment of gastroesophageal reflux disease**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 148

2021 Work RVU: 4.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.11

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43258 **Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43259 **Esophagogastroduodenoscopy, flexible, transoral; with endoscopic ultrasound examination, including the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis**

Global: 000 **Issue:** EGD **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 11 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** October 2008 **2019 est Medicare Utilization:** 34,294

2021 Work RVU: 4.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.10

RUC Recommendation: 4.74 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2009

43260 **Endoscopic retrograde cholangiopancreatography (ercp); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,795

2021 Work RVU: 5.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.90

RUC Recommendation: 5.95 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43261 **Endoscopic retrograde cholangiopancreatography (ercp); with biopsy, single or multiple**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 7,154

2021 Work RVU: 6.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.04

RUC Recommendation: 6.25 **Referred to CPT** January 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43262 **Endoscopic retrograde cholangiopancreatography (ercp); with sphincterotomy/papillotomy**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 30,450

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.19

RUC Recommendation: 6.60 **Referred to CPT** January 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43263 **Endoscopic retrograde cholangiopancreatography (ercp); with pressure measurement of sphincter of oddi**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 67

2021 Work RVU: 6.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.15

RUC Recommendation: 7.28 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

43264 **Endoscopic retrograde cholangiopancreatography (ercp); with removal of calculi/debris from biliary/pancreatic duct(s)**

Global: 000 **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:** 56,121

2021 Work RVU: 6.63
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.25

RUC Recommendation: 6.73 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43265 **Endoscopic retrograde cholangiopancreatography (ercp); with destruction of calculi, any method (eg, mechanical, electrohydraulic, lithotripsy)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,820

2021 Work RVU: 7.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.83

RUC Recommendation: 8.03 **Referred to CPT** February 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43266 **Esophagogastroduodenoscopy, flexible, transoral; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,767

2021 Work RVU: 3.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.93

RUC Recommendation: 4.40 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

43267 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of nasobiliary or nasopancreatic drainage tube**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43268 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde insertion of tube or stent into bile or pancreatic duct**

Global: **Issue:** ERCP **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43269 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde removal of foreign body and/or change of tube or stent**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43270 **Esophagogastroduodenoscopy, flexible, transoral; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** EGD **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** October 2012 **2019 est Medicare Utilization:** 20,628

2021 Work RVU: 4.01
2021 NF PE RVU: 18.21
2021 Fac PE RVU: 2.08

RUC Recommendation: 4.39 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43271 **Endoscopic retrograde cholangiopancreatography (ERCP); with endoscopic retrograde balloon dilation of ampulla, biliary and/or pancreatic duct(s)**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43272 **Endoscopic retrograde cholangiopancreatography (ERCP); with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

43273 **Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (list separately in addition to code(s) for primary procedure)**

Global: ZZZ **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 8,668

2021 Work RVU: 2.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.24 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43274 **Endoscopic retrograde cholangiopancreatography (ercp); with placement of endoscopic stent into biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 43,064

2021 Work RVU: 8.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.07

RUC Recommendation: 8.74 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43275 **Endoscopic retrograde cholangiopancreatography (ercp); with removal of foreign body(s) or stent(s) from biliary/pancreatic duct(s)**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 14,287

2021 Work RVU: 6.86
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.35

RUC Recommendation: 6.96 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43276 **Endoscopic retrograde cholangiopancreatography (ercp); with removal and exchange of stent(s), biliary or pancreatic duct, including pre- and post-dilation and guide wire passage, when performed, including sphincterotomy, when performed, each stent exchanged**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 16,434

2021 Work RVU: 8.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.24

RUC Recommendation: 9.10 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43277 **Endoscopic retrograde cholangiopancreatography (ercp); with trans-endoscopic balloon dilation of biliary/pancreatic duct(s) or of ampulla (sphincteroplasty), including sphincterotomy, when performed, each duct**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 6,694

2021 Work RVU: 6.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.37

RUC Recommendation: 7.11 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43278 **Endoscopic retrograde cholangiopancreatography (ercp); with ablation of tumor(s), polyp(s), or other lesion(s), including pre- and post-dilation and guide wire passage, when performed**

Global: 000 **Issue:** ERCP **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 12 **Specialty Developing Recommendation:** AGA, ASGE, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 600

2021 Work RVU: 7.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.81

RUC Recommendation: 8.08 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43450 **Dilation of esophagus, by unguided sound or bougie, single or multiple passes**

Global: 000 **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 71,670

2021 Work RVU: 1.28
2021 NF PE RVU: 4.18
2021 Fac PE RVU: 0.88

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

43453 **Dilation of esophagus, over guide wire**

Global: 000 **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,698

2021 Work RVU: 1.41
2021 NF PE RVU: 25.10
2021 Fac PE RVU: 0.93

RUC Recommendation: 1.51 **Referred to CPT** May 2012 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43456 **Dilation of esophagus, by balloon or dilator, retrograde** **Global:** **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43458 **Dilation of esophagus with balloon (30 mm diameter or larger) for achalasia** **Global:** **Issue:** Dilation of Esophagus **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 17 **Specialty Developing Recommendation:** AGA, ASGE, SAGES, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43760 **Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance** **Global:** **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** July 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

43762 **Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract** **Global:** 000 **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** September 2017 **2019 est Medicare Utilization:** 49,049

2021 Work RVU: 0.75
2021 NF PE RVU: 6.23
2021 Fac PE RVU: 0.23

RUC Recommendation: 0.75. Flag for Re-review. **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

43763 **Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract**

Global: 000 **Issue:** Gastrostomy Tube Replacement **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACEP, ACG, ACS, AGA, ASGE **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,711

2021 Work RVU: 1.41
2021 NF PE RVU: 9.02
2021 Fac PE RVU: 0.81

RUC Recommendation: 1.41. Flag for Re-review.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

44143 **Colectomy, partial; with end colostomy and closure of distal segment (hartmann type procedure)**

Global: 090 **Issue:** RAW **Screen:** High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** **First Identified:** October 2015 **2019 est Medicare Utilization:** 10,216

2021 Work RVU: 27.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.94

RUC Recommendation: 99214 visit appropriate. Remove from screen.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

44205 **Laparoscopy, surgical; colectomy, partial, with removal of terminal ileum with ileocolostomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** October 2008 **2019 est Medicare Utilization:** 12,383

2021 Work RVU: 22.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.62

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

Status Report: CMS Requests and Relativity Assessment Issues

44207 **Laparoscopy, surgical; colectomy, partial, with anastomosis, with coloproctostomy (low pelvic anastomosis)**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACS, ASCRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 9,951

2021 Work RVU: 31.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.07

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

44380 **Ileoscopy, through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Ileoscopy Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,038

2021 Work RVU: 0.87
2021 NF PE RVU: 4.95
2021 Fac PE RVU: 0.67

RUC Recommendation: 0.97 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44381 **Ileoscopy, through stoma; with transendoscopic balloon dilation**

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** May 2013 **2019 est Medicare Utilization:** 150

2021 Work RVU: 1.38
2021 NF PE RVU: 29.46
2021 Fac PE RVU: 0.88

RUC Recommendation: 1.48 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44382 **Ileoscopy, through stoma; with biopsy, single or multiple**

Global: 000 **Issue:** Ileoscopy Ileoscopy Ileoscopy Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,549

2021 Work RVU: 1.17
2021 NF PE RVU: 7.87
2021 Fac PE RVU: 0.83

RUC Recommendation: 1.27 **Referred to CPT** May 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44383 **Ileoscopy, through stoma; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

44384 **Ileoscopy, through stoma; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Ileoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 04 **Specialty Developing Recommendation:** AGA, ASGE, ACG **First Identified:** May 2013 **2019 est Medicare Utilization:** 124

2021 Work RVU: 2.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.30

RUC Recommendation: 3.11 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44385 **Endoscopic evaluation of small intestinal pouch (eg, kock pouch, ileal reservoir [s or j]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Pouchoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 05 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,312

2021 Work RVU: 1.20
2021 NF PE RVU: 5.09
2021 Fac PE RVU: 0.74

RUC Recommendation: 1.30 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44386 **Endoscopic evaluation of small intestinal pouch (eg, kock pouch, ileal reservoir [s or j]); with biopsy, single or multiple**

Global: 000 **Issue:** Pouchoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 05 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,832

2021 Work RVU: 1.50
2021 NF PE RVU: 7.87
2021 Fac PE RVU: 0.91

RUC Recommendation: 1.60 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44388 **Colonoscopy through stoma; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,180

2021 Work RVU: 2.72
2021 NF PE RVU: 6.39
2021 Fac PE RVU: 1.45

RUC Recommendation: 2.82 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

44389 **Colonoscopy through stoma; with biopsy, single or multiple**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,551

2021 Work RVU: 3.02
2021 NF PE RVU: 9.13
2021 Fac PE RVU: 1.61

RUC Recommendation: 3.12 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

44390 **Colonoscopy through stoma; with removal of foreign body(s)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 18

2021 Work RVU: 3.74
2021 NF PE RVU: 8.05
2021 Fac PE RVU: 1.97

RUC Recommendation: 3.82 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

44391 **Colonoscopy through stoma; with control of bleeding, any method**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 159

2021 Work RVU: 4.12
2021 NF PE RVU: 15.88
2021 Fac PE RVU: 2.12

RUC Recommendation: 4.22 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44392 **Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 297

2021 Work RVU: 3.53
2021 NF PE RVU: 7.58
2021 Fac PE RVU: 1.76

RUC Recommendation: 3.63 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44393 **Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

44394 **Colonoscopy through stoma; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,081

2021 Work RVU: 4.03
2021 NF PE RVU: 8.72
2021 Fac PE RVU: 2.03

RUC Recommendation: 4.13 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44397 **Colonoscopy through stoma; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44401 **Colonoscopy through stoma; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre-and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** September 2011 **2019 est Medicare Utilization:** 65

2021 Work RVU: 4.34
2021 NF PE RVU: 77.43
2021 Fac PE RVU: 2.24

RUC Recommendation: 4.44 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44402 **Colonoscopy through stoma; with endoscopic stent placement (including pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 4

2021 Work RVU: 4.70
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.40

RUC Recommendation: 4.96 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44403 **Colonoscopy through stoma; with endoscopic mucosal resection**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 76

2021 Work RVU: 5.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.75

RUC Recommendation: 5.81 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44404 **Colonoscopy through stoma; with directed submucosal injection(s), any substance**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 190

2021 Work RVU: 3.02
2021 NF PE RVU: 9.22
2021 Fac PE RVU: 1.61

RUC Recommendation: 3.13 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44405 **Colonoscopy through stoma; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 57

2021 Work RVU: 3.23
2021 NF PE RVU: 13.75
2021 Fac PE RVU: 1.75

RUC Recommendation: 3.33 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44406 **Colonoscopy through stoma; with endoscopic ultrasound examination, limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures** **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 4

2021 Work RVU: 4.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.13

RUC Recommendation: 4.41 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44407 **Colonoscopy through stoma; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the sigmoid, descending, transverse, or ascending colon and cecum and adjacent structures** **Global:** 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 4.96
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.51

RUC Recommendation: 5.06 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

44408 **Colonoscopy through stoma; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed**

Global: 000 **Issue:** Colonoscopy through stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** ASCRS, ACS, SAGES, AGA, ASGE, ACG **First Identified:** January 2014 **2019 est Medicare Utilization:** 76

2021 Work RVU: 4.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.15

RUC Recommendation: 4.24 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

44901 **Incision and drainage of appendiceal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

44970 **Laparoscopy, surgical, appendectomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACS **First Identified:** October 2008 **2019 est Medicare Utilization:** 22,448

2021 Work RVU: 9.45
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.13

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

45170 **Deleted from CPT**

Global: **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45171 **Excision of rectal tumor, transanal approach; not including muscularis propria (ie, partial thickness)**

Global: 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,516

2021 Work RVU: 8.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.72

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45172 **Excision of rectal tumor, transanal approach; including muscularis propria (ie, full thickness)**

Global: 090 **Issue:** Rectal Tumor Excision **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ASCRS, ASGS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,918

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.18

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45300 **Proctosigmoidoscopy, rigid; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)**

Global: 000 **Issue:** Diagnostic Proctosigmoidoscopy - Rigid **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 13 **Specialty Developing Recommendation:** ACS, ASCRS, SAGES **First Identified:** July 2016 **2019 est Medicare Utilization:** 23,267

2021 Work RVU: 0.80
2021 NF PE RVU: 2.99
2021 Fac PE RVU: 0.48

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45330 **Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** Harvard Valued - Utilization over 30,000 / MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** April 2011 **2019 est Medicare Utilization:** 50,795

2021 Work RVU: 0.84
2021 NF PE RVU: 4.65
2021 Fac PE RVU: 0.67

RUC Recommendation: 0.84 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45331 **Sigmoidoscopy, flexible; with biopsy, single or multiple**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 36,318

2021 Work RVU: 1.14
2021 NF PE RVU: 7.50
2021 Fac PE RVU: 0.81

RUC Recommendation: 1.14 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45332 **Sigmoidoscopy, flexible; with removal of foreign body(s)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 353

2021 Work RVU: 1.76
2021 NF PE RVU: 6.40
2021 Fac PE RVU: 1.07

RUC Recommendation: 1.85 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45333 **Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 734

2021 Work RVU: 1.55
2021 NF PE RVU: 8.32
2021 Fac PE RVU: 0.97

RUC Recommendation: 1.65 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45334 **Sigmoidoscopy, flexible; with control of bleeding, any method** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,411

2021 Work RVU: 2.00
2021 NF PE RVU: 13.83
2021 Fac PE RVU: 1.19

RUC Recommendation: 2.10 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45335 **Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 3,141

2021 Work RVU: 1.04
2021 NF PE RVU: 7.61
2021 Fac PE RVU: 0.76

RUC Recommendation: 1.15 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45337 **Sigmoidoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,691

2021 Work RVU: 2.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.99

RUC Recommendation: 2.20 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45338 **Sigmoidoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 5,383

2021 Work RVU: 2.05
2021 NF PE RVU: 6.77
2021 Fac PE RVU: 1.20

RUC Recommendation: 2.15 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45339 **Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45340 **Sigmoidoscopy, flexible; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,316

2021 Work RVU: 1.25
2021 NF PE RVU: 12.98
2021 Fac PE RVU: 0.85

RUC Recommendation: 1.35 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45341 **Sigmoidoscopy, flexible; with endoscopic ultrasound examination** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,713

2021 Work RVU: 2.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.25

RUC Recommendation: 2.43 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

45342 **Sigmoidoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s)** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:** 374

2021 Work RVU: 2.98
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.64

RUC Recommendation: 3.08 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45345 **Sigmoidoscopy, flexible; with transendoscopic stent placement (includes predilation)**

Global: **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45346 **Sigmoidoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** May 2013 **2019 est Medicare Utilization:** 1,183

2021 Work RVU: 2.81
2021 NF PE RVU: 76.84
2021 Fac PE RVU: 1.54

RUC Recommendation: 2.97 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45347 **Sigmoidoscopy, flexible; with placement of endoscopic stent (includes pre- and post-dilation and guide wire passage, when performed)**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 06 **Specialty Developing Recommendation:** ACG, ACS, AGA, ASGE, ASCRS, SAGES **First Identified:** May 2013 **2019 est Medicare Utilization:** 637

2021 Work RVU: 2.72
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.47

RUC Recommendation: 2.98 **Referred to CPT** May 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45349 **Sigmoidoscopy, flexible; with endoscopic mucosal resection**

Global: 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 632

2021 Work RVU: 3.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.86

RUC Recommendation: 3.83 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45350 **Sigmoidoscopy, flexible; with band ligation(s) (eg, hemorrhoids)** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,214

2021 Work RVU: 1.68
2021 NF PE RVU: 18.66
2021 Fac PE RVU: 1.04

RUC Recommendation: 1.78 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45355 **Colonoscopy, rigid or flexible, transabdominal via colotomy, single or multiple** **Global:** **Issue:** Colonoscopy via stoma **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 08 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45378 **Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)** **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS High Expenditure Procedural Codes1 / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 345,987

2021 Work RVU: 3.26
2021 NF PE RVU: 6.56
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.36 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45379 **Colonoscopy, flexible; with removal of foreign body(s)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 930

2021 Work RVU: 4.28
2021 NF PE RVU: 8.32
2021 Fac PE RVU: 2.17

RUC Recommendation: 4.37 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45380 **Colonoscopy, flexible; with biopsy, single or multiple** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,054,879

2021 Work RVU: 3.56
2021 NF PE RVU: 9.25
2021 Fac PE RVU: 1.87

RUC Recommendation: 3.66 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

45381 **Colonoscopy, flexible; with directed submucosal injection(s), any substance** **Global:** 000 **Issue:** Colonoscopy **Screen:** CMS Fastest Growing / MPC List / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** October 2008 **2019 est Medicare Utilization:** 82,892

2021 Work RVU: 3.56
2021 NF PE RVU: 9.36
2021 Fac PE RVU: 1.87

RUC Recommendation: 3.67 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2010

45382 **Colonoscopy, flexible; with control of bleeding, any method** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 24,121

2021 Work RVU: 4.66
2021 NF PE RVU: 16.07
2021 Fac PE RVU: 2.36

RUC Recommendation: 4.76 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45383 **Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique**

Global: **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

45384 **Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 77,739

2021 Work RVU: 4.07
2021 NF PE RVU: 10.23
2021 Fac PE RVU: 2.01

RUC Recommendation: 4.17 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

45385 **Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List / Codes Reported Together 75%or More-Part4 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 13 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES **First Identified:** October 2010 **2019 est Medicare Utilization:** 971,282

2021 Work RVU: 4.57
2021 NF PE RVU: 8.62
2021 Fac PE RVU: 2.31

RUC Recommendation: 4.57 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45386 **Colonoscopy, flexible; with transendoscopic balloon dilation** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,321

2021 Work RVU: 3.77
2021 NF PE RVU: 14.77
2021 Fac PE RVU: 1.94

RUC Recommendation: 3.87 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45387 **Colonoscopy, flexible, proximal to splenic flexure; with transendoscopic stent placement (includes predilation)** **Global:** **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

45388 **Colonoscopy, flexible; with ablation of tumor(s), polyp(s), or other lesion(s) (includes pre- and post-dilation and guide wire passage, when performed)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 26,744

2021 Work RVU: 4.88
2021 NF PE RVU: 79.44
2021 Fac PE RVU: 2.41

RUC Recommendation: 4.98 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45389 **Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 420

2021 Work RVU: 5.24
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.60

RUC Recommendation: 5.50 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45390 **Colonoscopy, flexible; with endoscopic mucosal resection** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 23,129

2021 Work RVU: 6.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.98

RUC Recommendation: 6.35 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45391 **Colonoscopy, flexible; with endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 932

2021 Work RVU: 4.64
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.36

RUC Recommendation: 4.95 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45392 **Colonoscopy, flexible; with transendoscopic ultrasound guided intramural or transmural fine needle aspiration/biopsy(s), includes endoscopic ultrasound examination limited to the rectum, sigmoid, descending, transverse, or ascending colon and cecum, and adjacent structures** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 86

2021 Work RVU: 5.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.74

RUC Recommendation: 5.60 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

45393 **Colonoscopy, flexible; with decompression (for pathologic distention) (eg, volvulus, megacolon), including placement of decompression tube, when performed**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,112

2021 Work RVU: 4.68
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.10

RUC Recommendation: 4.78 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

45398 **Colonoscopy, flexible; with band ligation(s) (eg, hemorrhoids)**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** January 2014 **2019 est Medicare Utilization:** 3,509

2021 Work RVU: 4.20
2021 NF PE RVU: 20.44
2021 Fac PE RVU: 2.06

RUC Recommendation: 4.30 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

46020 **Placement of seton**

Global: 010 **Issue:** Placement/Removal of Seton **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 16 **Specialty Developing Recommendation:** ACS, ASCRS (col) **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,325

2021 Work RVU: 3.00
2021 NF PE RVU: 4.92
2021 Fac PE RVU: 3.50

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

46030 **Removal of anal seton, other marker**

Global: 010 **Issue:** Placement/ Removal of Seton **Screen:** 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 16 **Specialty Developing Recommendation:** ACS, ASCRS (col) **First Identified:** April 2020 **2019 est Medicare Utilization:** 339

2021 Work RVU: 1.26
2021 NF PE RVU: 3.09
2021 Fac PE RVU: 1.17

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

46200 **Fissurectomy, including sphincterotomy, when performed**

Global: 090 **Issue:** Fissurectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACS **First Identified:** September 2007 **2019 est Medicare Utilization:** 992

2021 Work RVU: 3.59
2021 NF PE RVU: 10.05
2021 Fac PE RVU: 5.72

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

46500 **Injection of sclerosing solution, hemorrhoids**

Global: 010 **Issue:** Hemorrhoid Injection **Screen:** 010-Day Global Post-Operative Visits / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 24 **Specialty Developing Recommendation:** ACS, ASCRS (colon) **First Identified:** January 2014 **2019 est Medicare Utilization:** 12,575

2021 Work RVU: 1.74
2021 NF PE RVU: 7.52
2021 Fac PE RVU: 3.53

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47011 **Hepatotomy; for percutaneous drainage of abscess or cyst, 1 or 2 stages**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47135 **Liver allotransplantation, orthotopic, partial or whole, from cadaver or living donor, any age**

Global: 090 **Issue:** Liver Allotransplantation **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACS, ASTS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,590

2021 Work RVU: 90.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 46.85

RUC Recommendation: 91.78 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47136 **Liver allotransplantation; heterotopic, partial or whole, from cadaver or living donor, any age**

Global: **Issue:** RAW **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** ACS, ASTS **First Identified:** April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47382 **Ablation, 1 or more liver tumor(s), percutaneous, radiofrequency**

Global: 010 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 3,121

2021 Work RVU: 14.97
2021 NF PE RVU: 108.30
2021 Fac PE RVU: 5.04

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47490 **Cholecystostomy, percutaneous, complete procedure, including imaging guidance, catheter placement, cholecystogram when performed, and radiological supervision and interpretation**

Global: 010 **Issue:** Cholecystostomy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 04 **Specialty Developing Recommendation:** ACR

First Identified: October 2008 **2019 est Medicare Utilization:** 12,075

2021 Work RVU: 4.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.55

RUC Recommendation: 4.76 **Referred to CPT** June 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

47500 **Injection procedure for percutaneous transhepatic cholangiography**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47505 **Injection procedure for cholangiography through an existing catheter (eg, percutaneous transhepatic or T-tube)**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47510 **Introduction of percutaneous transhepatic catheter for biliary drainage**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47511 **Introduction of percutaneous transhepatic stent for internal and external biliary drainage**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47525 **Change of percutaneous biliary drainage catheter**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47530 **Revision and/or reinsertion of transhepatic tube**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

47531 **Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 8,621

2021 Work RVU: 1.30
2021 NF PE RVU: 11.26
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.30 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47532 **Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (eg, percutaneous transhepatic cholangiogram)**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 549

2021 Work RVU: 4.25
2021 NF PE RVU: 21.37
2021 Fac PE RVU: 1.49

RUC Recommendation: 4.50 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47533 **Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,518

2021 Work RVU: 5.38
2021 NF PE RVU: 31.52
2021 Fac PE RVU: 1.79

RUC Recommendation: 5.63 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47534 **Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; internal-external**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 4,467

2021 Work RVU: 7.60
2021 NF PE RVU: 33.18
2021 Fac PE RVU: 2.42

RUC Recommendation: 7.85 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47535 **Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 438

2021 Work RVU: 3.95
2021 NF PE RVU: 24.60
2021 Fac PE RVU: 1.35

RUC Recommendation: 4.20 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47536 **Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 14,577

2021 Work RVU: 2.61
2021 NF PE RVU: 17.79
2021 Fac PE RVU: 0.96

RUC Recommendation: 2.86 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47537 **Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,737

2021 Work RVU: 1.84
2021 NF PE RVU: 12.71
2021 Fac PE RVU: 0.77

RUC Recommendation: 1.85 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47538 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,025

2021 Work RVU: 4.75
2021 NF PE RVU: 120.85
2021 Fac PE RVU: 1.62

RUC Recommendation: 5.00 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47539 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, without placement of separate biliary drainage catheter**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 135

2021 Work RVU: 8.75
2021 NF PE RVU: 128.69
2021 Fac PE RVU: 2.55

RUC Recommendation: 9.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47540 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 223

2021 Work RVU: 9.03
2021 NF PE RVU: 131.53
2021 Fac PE RVU: 2.84

RUC Recommendation: 9.28 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47541 **Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation, new access**

Global: 000 **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 170

2021 Work RVU: 6.75
2021 NF PE RVU: 29.20
2021 Fac PE RVU: 2.22

RUC Recommendation: 7.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47542 **Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, each duct (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,346

2021 Work RVU: 2.85
2021 NF PE RVU: 12.52
2021 Fac PE RVU: 0.82

RUC Recommendation: 2.85 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47543 **Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps, and/or needle), including imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation, single or multiple (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 692

2021 Work RVU: 3.00
2021 NF PE RVU: 9.70
2021 Fac PE RVU: 0.89

RUC Recommendation: 3.00 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

47544 **Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:** 322

2021 Work RVU: 3.28
2021 NF PE RVU: 24.66
2021 Fac PE RVU: 0.93

RUC Recommendation: 3.28 **Referred to CPT** February 2015 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

47560 **Laparoscopy, surgical; with guided transhepatic cholangiography, without biopsy**

Global: **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:**

First Identified: July 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

47562 **Laparoscopy, surgical; cholecystectomy**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ACS

First Identified: September 2011 **2019 est Medicare Utilization:** 100,881

2021 Work RVU: 10.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.54

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 3.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

47563 **Laparoscopy, surgical; cholecystectomy with cholangiography**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:** 38,983

2021 Work RVU: 11.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.04

RUC Recommendation: No further action. 12.11

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

47600 **Cholecystectomy;**

Global: 090 **Issue:** Cholecystectomy **Screen:** CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 36 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 8,195

2021 Work RVU: 17.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.02

RUC Recommendation: 20.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

47605 **Cholecystectomy; with cholangiography**

Global: 090 **Issue:** Cholecystectomy **Screen:** CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 36 **Specialty Developing Recommendation:** ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,408

2021 Work RVU: 18.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.45

RUC Recommendation: 21.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

48102 **Biopsy of pancreas, percutaneous needle**

Global: 010 **Issue:** Percutaneous Needle Biopsy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** SIR **First Identified:** September 2007 **2019 est Medicare Utilization:** 960

2021 Work RVU: 4.70
2021 NF PE RVU: 10.86
2021 Fac PE RVU: 1.75

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

48511 **External drainage, pseudocyst of pancreas; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49021 **Drainage of peritoneal abscess or localized peritonitis, exclusive of appendiceal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49041 **Drainage of subdiaphragmatic or subphrenic abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49061 **Drainage of retroperitoneal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49080 **Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial**

Global: **Issue:** Peritoneocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 5 **Specialty Developing Recommendation:** ACR, AGA, ASGE, AUR, SIR **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

49081 **Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent**

Global: **Issue:** Peritoneocentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 5 **Specialty Developing Recommendation:** ACR, AGA, ASGE, AUR, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49082 **Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,210

2021 Work RVU: 1.24
2021 NF PE RVU: 5.06
2021 Fac PE RVU: 0.72

RUC Recommendation: 1.35 **Referred to CPT** June 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49083 **Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 265,269

2021 Work RVU: 2.00
2021 NF PE RVU: 6.90
2021 Fac PE RVU: 0.91

RUC Recommendation: 2.00 **Referred to CPT** June 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49084 **Peritoneal lavage, including imaging guidance, when performed** **Global:** 000 **Issue:** Abdominal Paracentesis **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 05 **Specialty Developing Recommendation:** ACR, ACS, AGA, ASGE, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,879

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.75

RUC Recommendation: 2.50 **Referred to CPT** June 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49405 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); visceral (eg, kidney, liver, spleen, lung/mediastinum), percutaneous**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 5,880

2021 Work RVU: 4.00
2021 NF PE RVU: 22.98
2021 Fac PE RVU: 1.32

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49406 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 33,397

2021 Work RVU: 4.00
2021 NF PE RVU: 22.99
2021 Fac PE RVU: 1.32

RUC Recommendation: 4.25 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49407 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal**

Global: 000 **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** January 2012 **2019 est Medicare Utilization:** 243

2021 Work RVU: 4.25
2021 NF PE RVU: 18.03
2021 Fac PE RVU: 1.36

RUC Recommendation: 4.50 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49418 **Insertion of tunneled intraperitoneal catheter (eg, dialysis, intraperitoneal chemotherapy instillation, management of ascites), complete procedure, including imaging guidance, catheter placement, contrast injection when performed, and radiological supervision and interpretation, percutaneous**

Global: 000 **Issue:** Intraperitoneal Catheter Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,497

2021 Work RVU: 3.96
2021 NF PE RVU: 29.31
2021 Fac PE RVU: 1.50

RUC Recommendation: 4.21 **Referred to CPT** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

49420 **Deleted from CPT**

Global: **Issue:** Insertion of Intraperitoneal Cannula or Catheter **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49421 **Insertion of tunneled intraperitoneal catheter for dialysis, open**

Global: 000 **Issue:** Intraperitoneal Catheter Codes **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 11 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,848

2021 Work RVU: 4.21
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.53

RUC Recommendation: 4.21 **Referred to CPT** February 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49422 **Removal of tunneled intraperitoneal catheter**

Global: 000 **Issue:** Removal of Intraperitoneal Catheter **Screen:** Site of Service Anomaly - 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACS, SVS

First Identified: October 2016

2019 est Medicare Utilization: 12,368

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.62

RUC Recommendation: 4.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

49505 **Repair initial inguinal hernia, age 5 years or older; reducible**

Global: 090 **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** ACS

First Identified: September 2011

2019 est Medicare Utilization: 50,710

2021 Work RVU: 7.96
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.60

RUC Recommendation: Reaffirmed

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

49507 **Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated**

Global: 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 29 **Specialty Developing Recommendation:** ACS

First Identified: September 2007

2019 est Medicare Utilization: 10,329

2021 Work RVU: 9.09
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.12

RUC Recommendation: 10.05

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

49521 **Repair recurrent inguinal hernia, any age; incarcerated or strangulated**

Global: 090 **Issue:** Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 29 **Specialty Developing Recommendation:** ACS

First Identified: September 2007

2019 est Medicare Utilization: 1,809

2021 Work RVU: 11.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.00

RUC Recommendation: 12.44

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

49560 **Repair initial incisional or ventral hernia; reducible**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 22,089

2021 Work RVU: 11.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.11

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49561 **Repair initial incisional or ventral hernia; incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 12,726

2021 Work RVU: 15.38
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.45

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49565 **Repair recurrent incisional or ventral hernia; reducible**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,211

2021 Work RVU: 12.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.46

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49566 **Repair recurrent incisional or ventral hernia; incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 3,748

2021 Work RVU: 15.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.51

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49568 **Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (list separately in addition to code for the incisional or ventral hernia repair)**

Global: ZZZ **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 27,767

2021 Work RVU: 4.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.82

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49570 **Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 616

2021 Work RVU: 6.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.93

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49572 **Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 451

2021 Work RVU: 7.87
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.60

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49580 **Repair umbilical hernia, younger than age 5 years; reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU: 4.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.42

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49582 **Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 0

2021 Work RVU: 7.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.50

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49585 **Repair umbilical hernia, age 5 years or older; reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 18,847

2021 Work RVU: 6.59
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.10

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49587 **Repair umbilical hernia, age 5 years or older; incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,947

2021 Work RVU: 7.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.37

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49590 **Repair spigelian hernia** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 714

2021 Work RVU: 8.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.98

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49652 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2019 est Medicare Utilization:** 9,327

2021 Work RVU: 11.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.26

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49653 **Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2019 est Medicare Utilization:** 5,848

2021 Work RVU: 14.94
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.02

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49654 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible** **Global:** 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2019 est Medicare Utilization:** 7,253

2021 Work RVU: 13.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.95

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49655 **Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** June 2010 **2019 est Medicare Utilization:** 4,804

2021 Work RVU: 16.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.73

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49656 **Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 1,697

2021 Work RVU: 15.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.43

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49657 **Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated**

Global: 090 **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:** 1,503

2021 Work RVU: 22.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.62

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2021 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

49X01

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 6.27 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49X02

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 9.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X03

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 10.80 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X04

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 14.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X05

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 14.88 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49X06

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 20.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X07

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 7.75 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X08

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 10.79 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X09

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 12.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49X10

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: 16.50 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X11

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: 16.97 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X12

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: 24.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X13

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: 14.24 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

49X14

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 18.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

49X15

Global: **Issue:** Anterior Abdominal Hernia Repair **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 09 **Specialty Developing Recommendation:** ACS, ASCRS (col), SAGES **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 5.00 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

50021 **Drainage of perirenal or renal abscess; percutaneous**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50080 **Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; up to 2 cm**

Global: 090 **Issue:** Percutaneous Nephrostolithotomy **Screen:** Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 25 **Specialty Developing Recommendation:** AUA, SIR **First Identified:** October 2019 **2019 est Medicare Utilization:** 2,659

2021 Work RVU: 15.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.75

RUC Recommendation: Refer to CPT **Referred to CPT** September 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

50081 **Percutaneous nephrostolithotomy or pyelostolithotomy, with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction; over 2 cm**

Global: 090 **Issue:** Percutaneous Nephrostolithotomy **Screen:** Site of Service Anomaly - 2019 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 25 **Specialty Developing Recommendation:** AUA, SIR **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,937

2021 Work RVU: 23.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.97

RUC Recommendation: Refer to CPT **Referred to CPT** September 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

50200 **Renal biopsy; percutaneous, by trocar or needle**

Global: 000 **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 38,395

2021 Work RVU: 2.38
2021 NF PE RVU: 13.71
2021 Fac PE RVU: 1.10

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50360 **Renal allotransplantation, implantation of graft; without recipient nephrectomy** **Global:** 090 **Issue:** Renal Allotransplantation **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** July 2012 **2019 est Medicare Utilization:** 12,479

2021 Work RVU: 39.88
2021 NF PE RVU: NA
2021 Fac PE RVU: 22.26

RUC Recommendation: 40.90 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

50387 **Removal and replacement of externally accessible nephroureteral catheter (eg, external/internal stent) requiring fluoroscopic guidance, including radiological supervision and interpretation** **Global:** 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 7,721

2021 Work RVU: 1.75
2021 NF PE RVU: 15.40
2021 Fac PE RVU: 0.51

RUC Recommendation: 2.00 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

50392 **Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous** **Global:** **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50393 **Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

50394 **Injection procedure for pyelography (as nephrostogram, pyelostogram, antegrade pyeloureterograms) through nephrostomy or pyelostomy tube, or indwelling ureteral catheter**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

50395 **Introduction of guide into renal pelvis and/or ureter with dilation to establish nephrostomy tract, percutaneous**

Global: **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50398 **Change of nephrostomy or pyelostomy tube**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

50430 **Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,007

2021 Work RVU: 2.90
2021 NF PE RVU: 15.41
2021 Fac PE RVU: 1.28

RUC Recommendation: 3.15 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

50431 **Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 8,818

2021 Work RVU: 1.10
2021 NF PE RVU: 7.92
2021 Fac PE RVU: 0.69

RUC Recommendation: 1.42 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50432 **Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 28,285

2021 Work RVU: 4.00
2021 NF PE RVU: 23.39
2021 Fac PE RVU: 1.57

RUC Recommendation: 4.00 **Referred to CPT** October 2014 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

50433 **Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 5,572

2021 Work RVU: 5.05
2021 NF PE RVU: 29.70
2021 Fac PE RVU: 1.85

RUC Recommendation: 5.05 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

50434 **Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 2,477

2021 Work RVU: 3.75
2021 NF PE RVU: 24.12
2021 Fac PE RVU: 1.45

RUC Recommendation: 4.20 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50435 **Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 46,684

2021 Work RVU: 1.82
2021 NF PE RVU: 16.19
2021 Fac PE RVU: 0.89

RUC Recommendation: 2.00 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

50436 **Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed;**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 607

2021 Work RVU: 2.78
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.31

RUC Recommendation: 3.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

50437 **Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, with postprocedure tube placement, when performed; including new access into the renal collecting system**

Global: 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,196

2021 Work RVU: 4.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.93

RUC Recommendation: 5.44 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50542 **Laparoscopy, surgical; ablation of renal mass lesion(s), including intraoperative ultrasound guidance and monitoring, when performed**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** AUA

First Identified: October 2008 **2019 est Medicare Utilization:** 197

2021 Work RVU: 21.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.11

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

50548 **Laparoscopy, surgical; nephrectomy with total ureterectomy**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** AUA

First Identified: October 2008 **2019 est Medicare Utilization:** 2,422

2021 Work RVU: 25.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.78

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

50590 **Lithotripsy, extracorporeal shock wave**

Global: 090 **Issue:** Lithotripsy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 42 **Specialty Developing Recommendation:** AUA

First Identified: September 2011 **2019 est Medicare Utilization:** 54,658

2021 Work RVU: 9.77
2021 NF PE RVU: 11.03
2021 Fac PE RVU: 5.72

RUC Recommendation: 9.77

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

50605 **Ureterotomy for insertion of indwelling stent, all types**

Global: 090 **Issue:** Ureterotomy **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AUA, SIR

First Identified: October 2008 **2019 est Medicare Utilization:** 3,602

2021 Work RVU: 16.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.05

RUC Recommendation: Review action plan at the RAW Oct 2015. CPT Assistant article published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

50606 **Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 104

2021 Work RVU: 3.16
2021 NF PE RVU: 13.99
2021 Fac PE RVU: 0.91

RUC Recommendation: 3.16 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50693 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,504

2021 Work RVU: 3.96
2021 NF PE RVU: 27.17
2021 Fac PE RVU: 1.58

RUC Recommendation: 4.60 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

50694 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 981

2021 Work RVU: 5.25
2021 NF PE RVU: 29.30
2021 Fac PE RVU: 1.99

RUC Recommendation: 6.00 **Referred to CPT** October 2014 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

50695 **Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter**

Global: 000 **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,321

2021 Work RVU: 6.80
2021 NF PE RVU: 34.84
2021 Fac PE RVU: 2.52

RUC Recommendation: 7.55 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

50705 **Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 65

2021 Work RVU: 4.03
2021 NF PE RVU: 53.59
2021 Fac PE RVU: 0.65

RUC Recommendation: 4.03 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

50706 **Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 08 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2014 **2019 est Medicare Utilization:** 1,459

2021 Work RVU: 3.80
2021 NF PE RVU: 23.29
2021 Fac PE RVU: 1.11

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51040 **Cystostomy, cystotomy with drainage**

Global: 090 **Issue:** Cystostomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 5,029

2021 Work RVU: 4.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.48

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

51102 **Aspiration of bladder; with insertion of suprapubic catheter**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 45 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 14,265

2021 Work RVU: 2.70
2021 NF PE RVU: 4.21
2021 Fac PE RVU: 1.23

RUC Recommendation: 2.70

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

51700 **Bladder irrigation, simple, lavage and/or instillation**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA

First Identified: July 2015 **2019 est Medicare Utilization:** 194,801

2021 Work RVU: 0.60
2021 NF PE RVU: 1.63
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.60

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

51701 **Insertion of non-indwelling bladder catheter (eg, straight catheterization for residual urine)**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA

First Identified: July 2015 **2019 est Medicare Utilization:** 168,108

2021 Work RVU: 0.50
2021 NF PE RVU: 0.78
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

51702 **Insertion of temporary indwelling bladder catheter; simple (eg, foley)**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 234,004

2021 Work RVU: 0.50
2021 NF PE RVU: 1.32
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

51703 **Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)**

Global: 000 **Issue:** Bladder Catheter **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 32 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 54,647

2021 Work RVU: 1.47
2021 NF PE RVU: 2.73
2021 Fac PE RVU: 0.58

RUC Recommendation: 1.47 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

51720 **Bladder instillation of anticarcinogenic agent (including retention time)**

Global: 000 **Issue:** Treatment of Bladder Lesion **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 33 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 160,447

2021 Work RVU: 0.87
2021 NF PE RVU: 1.64
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.87 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

51726 **Complex cystometrogram (ie, calibrated electronic equipment);**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2008 **2019 est Medicare Utilization:** 4,438

2021 Work RVU: 1.71
2021 NF PE RVU: 7.14
2021 Fac PE RVU: NA

RUC Recommendation: 1.71 **Referred to CPT** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51727 **Complex cystometrogram (ie, calibrated electronic equipment); with urethral pressure profile studies (ie, urethral closure pressure profile), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,982

2021 Work RVU: 2.11
2021 NF PE RVU: 8.52
2021 Fac PE RVU: NA

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

51728 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 85,150

2021 Work RVU: 2.11
2021 NF PE RVU: 8.65
2021 Fac PE RVU: NA

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

51729 **Complex cystometrogram (ie, calibrated electronic equipment); with voiding pressure studies (ie, bladder voiding pressure) and urethral pressure profile studies (ie, urethral closure pressure profile), any technique**

Global: 000 **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,880

2021 Work RVU: 2.51
2021 NF PE RVU: 8.84
2021 Fac PE RVU: NA

RUC Recommendation: 2.51 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51736 **Simple uroflowmetry (ufr) (eg, stop-watch flow rate, mechanical uroflowmeter)** **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 11 **Specialty Developing Recommendation:** AUA **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,797

2021 Work RVU: 0.17
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51741 **Complex uroflowmetry (eg, calibrated electronic equipment)** **Global:** XXX **Issue:** Uroflowmetry **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 11 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 423,494

2021 Work RVU: 0.17
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

51772 **Deleted from CPT** **Global:** **Issue:** Urodynamic Studies **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 16 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51784 **Electromyography studies (emg) of anal or urethral sphincter, other than needle, any technique**

Global: XXX **Issue:** Electromyography Studies (EMG) **Screen:** Codes Reported Together 75% or More-Part2 / CMS High Expenditure Procedural Codes2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AUA **First Identified:** October 2012 **2019 est Medicare Utilization:** 142,000

2021 Work RVU: 0.75
2021 NF PE RVU: 1.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.75. Maintain, CPT Assistant addressed issues identified.

Referred to CPT February 2014 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2014

51792 **Stimulus evoked response (eg, measurement of bulbocavernosus reflex latency time)**

Global: 000 **Issue:** Urinary Reflex Studies with EMG **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AUA **First Identified:** October 2012 **2019 est Medicare Utilization:** 7,152

2021 Work RVU: 1.10
2021 NF PE RVU: 6.72
2021 Fac PE RVU: NA

RUC Recommendation: CPT edits and CPT Assistant article complete.

Referred to CPT February 2014 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2014

51795 **Deleted from CPT**

Global: **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

51797 **Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Urology Studies **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:**

First Identified: February 2008

2019 est Medicare Utilization: 116,064

2021 Work RVU: 0.80
2021 NF PE RVU: 4.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** February 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

51798 **Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging**

Global: XXX **Issue:** Voiding Pressure Studies **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 25 **Specialty Developing Recommendation:** AUA

First Identified: July 2015

2019 est Medicare Utilization: 2,169,510

2021 Work RVU: 0.00
2021 NF PE RVU: 0.29
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

52000 **Cystourethroscopy (separate procedure)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 35 **Specialty Developing Recommendation:** AUA, ACOG

First Identified: October 2010

2019 est Medicare Utilization: 897,375

2021 Work RVU: 1.53
2021 NF PE RVU: 5.21
2021 Fac PE RVU: 0.63

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52214 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) of trigone, bladder neck, prostatic fossa, urethra, or periurethral glands**

Global: 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth1 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AUA **First Identified:** June 2008 **2019 est Medicare Utilization:** 16,853

2021 Work RVU: 3.50
2021 NF PE RVU: 19.06
2021 Fac PE RVU: 1.20

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2009 and May 2016

52224 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) or treatment of minor (less than 0.5 cm) lesion(s) with or without biopsy**

Global: 000 **Issue:** Cystourethroscopy **Screen:** High Volume Growth1 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:** 36,291

2021 Work RVU: 4.05
2021 NF PE RVU: 19.41
2021 Fac PE RVU: 1.39

RUC Recommendation: 4.05 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2009 and May 2016

52234 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; small bladder tumor(s) (0.5 up to 2.0 cm)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 28,317

2021 Work RVU: 4.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.96

RUC Recommendation: 4.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

Status Report: CMS Requests and Relativity Assessment Issues

52235 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; medium bladder tumor(s) (2.0 to 5.0 cm)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AUA **First Identified:** April 2011 **2019 est Medicare Utilization:** 33,411

2021 Work RVU: 5.44
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.27

RUC Recommendation: 5.44 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

52240 **Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; large bladder tumor(s)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,956

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.98

RUC Recommendation: 8.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2016

52281 **Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection procedure for cystography, male or female**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 38 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 62,618

2021 Work RVU: 2.75
2021 NF PE RVU: 6.79
2021 Fac PE RVU: 1.33

RUC Recommendation: 2.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52287 **Cystourethroscopy, with injection(s) for chemodenervation of the bladder** **Global:** 000 **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 51,037

2021 Work RVU: 3.20
2021 NF PE RVU: 7.82
2021 Fac PE RVU: 1.32

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

52332 **Cystourethroscopy, with insertion of indwelling ureteral stent (eg, gibbons or double-j type)** **Global:** 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 13 **Specialty Developing Recommendation:** AUA **First Identified:** October 2009 **2019 est Medicare Utilization:** 151,015

2021 Work RVU: 2.82
2021 NF PE RVU: 9.94
2021 Fac PE RVU: 1.35

RUC Recommendation: 2.82 **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

52334 **Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde** **Global:** 000 **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 289

2021 Work RVU: 3.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.54

RUC Recommendation: 3.37 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52341 **Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 2,487

2021 Work RVU: 5.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.24

RUC Recommendation: 5.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52342 **Cystourethroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 191

2021 Work RVU: 5.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.41

RUC Recommendation: 5.85 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52343 **Cystourethroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 21

2021 Work RVU: 6.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.65

RUC Recommendation: 6.55 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52344 **Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,393

2021 Work RVU: 7.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.82

RUC Recommendation: 7.05 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52345 **Cystourethroscopy with ureteroscopy; with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 480

2021 Work RVU: 7.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.00

RUC Recommendation: 7.55 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52346 **Cystourethroscopy with ureteroscopy; with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)**

Global: 000 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** April 2008 **2019 est Medicare Utilization:** 212

2021 Work RVU: 8.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.35

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52351 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 22,929

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.34

RUC Recommendation: 5.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52352 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with removal or manipulation of calculus (ureteral catheterization is included)**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 24,811

2021 Work RVU: 6.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.72

RUC Recommendation: 6.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52353 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 13 **Specialty Developing Recommendation:** AUA **First Identified:** April 2011 **2019 est Medicare Utilization:** 11,180

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.98

RUC Recommendation: 7.50 **Referred to CPT** February 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52354 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with biopsy and/or fulguration of ureteral or renal pelvic lesion**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 9,144

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.15

RUC Recommendation: 8.58 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

52355 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic tumor**

Global: 000 **Issue:** Cystourethroscopy and Ureteroscopy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 23 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,007

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.49

RUC Recommendation: 10.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52356 **Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy including insertion of indwelling ureteral stent (eg, gibbons or double-j type)**

Global: 000 **Issue:** Cystourethroscopy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 13 **Specialty Developing Recommendation:** AUA **First Identified:** January 2013 **2019 est Medicare Utilization:** 78,507

2021 Work RVU: 8.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.11

RUC Recommendation: 8.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52400 **Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 115

2021 Work RVU: 8.69
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.19

RUC Recommendation: 8.69 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52442 **Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PE Subcommittee **Screen:** PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AUA, AACU **First Identified:** April 2020 **2019 est Medicare Utilization:** 101,717

2021 Work RVU: 1.01
2021 NF PE RVU: 28.12
2021 Fac PE RVU: 0.35

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52500 **Transurethral resection of bladder neck (separate procedure)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,173

2021 Work RVU: 8.14
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.24

RUC Recommendation: 8.14 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52601 **Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)** **Global:** 090 **Issue:** Transurethral Electrosurgical Resection of Prostate (TURP) **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 26 **Specialty Developing Recommendation:** AUA **First Identified:** October 2015 **2019 est Medicare Utilization:** 44,942

2021 Work RVU: 13.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.56

RUC Recommendation: 13.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

52640 **Transurethral resection; of postoperative bladder neck contracture** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 45 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,396

2021 Work RVU: 4.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.98

RUC Recommendation: 4.79 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

52648 **Laser vaporization of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)**

Global: 090 **Issue:** Laser Surgery of Prostate **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** AUA **First Identified:** February 2008 **2019 est Medicare Utilization:** 18,059

2021 Work RVU: 12.15
2021 NF PE RVU: 36.73
2021 Fac PE RVU: 6.60

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

53445 **Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 2,071

2021 Work RVU: 13.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.55

RUC Recommendation: 13.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

53850 **Transurethral destruction of prostate tissue; by microwave thermotherapy**

Global: 090 **Issue:** Transurethral Destruction of Prostate Tissue **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 43 **Specialty Developing Recommendation:** AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,363

2021 Work RVU: 5.42
2021 NF PE RVU: 40.18
2021 Fac PE RVU: 4.25

RUC Recommendation: 10.08 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

54405 **Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 45 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 5,217

2021 Work RVU: 14.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.40

RUC Recommendation: 14.39

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

54410 **Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 31 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 1,286

2021 Work RVU: 15.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.22

RUC Recommendation: 15.18

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

54520 **Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach**

Global: 090 **Issue:** Removal of Testical **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 2,671

2021 Work RVU: 5.30
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.61

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

54530 **Orchiectomy, radical, for tumor; inguinal approach**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 65 **Specialty Developing Recommendation:** AUA

First Identified: September 2007 **2019 est Medicare Utilization:** 1,190

2021 Work RVU: 8.46
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.37

RUC Recommendation: 8.46

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

55700 **Biopsy, prostate; needle or punch, single or multiple, any approach**

Global: 000 **Issue:** Biopsy of Prostate **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 36 **Specialty Developing Recommendation:** AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 156,362

2021 Work RVU: 2.50
2021 NF PE RVU: 4.57
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55706 **Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance**

Global: 010 **Issue:** RAW **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 52 **Specialty Developing Recommendation:** **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,297

2021 Work RVU: 6.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.95

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

55840 **Prostatectomy, retropubic radical, with or without nerve sparing;**

Global: 090 **Issue:** **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** October 2013 **2019 est Medicare Utilization:** 1,610

2021 Work RVU: 21.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.22

RUC Recommendation: 21.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55842 **Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)**

Global: 090 **Issue:** **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** October 2013 **2019 est Medicare Utilization:** 150

2021 Work RVU: 21.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.24

RUC Recommendation: 24.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

55845 **Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes**

Global: 090 **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 31 **Specialty Developing Recommendation:** AUA **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,030

2021 Work RVU: 25.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.53

RUC Recommendation: 29.07 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55866 **Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed**

Global: 090 **Issue:** Laparoscopic Radical Prostatectomy **Screen:** New Technology / CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 27 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 20,334

2021 Work RVU: 26.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.05

RUC Recommendation: 26.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

55873 **Cryosurgical ablation of the prostate (includes ultrasonic guidance and monitoring)**

Global: 090 **Issue:** Cryoablation of Prostate **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 25 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,648

2021 Work RVU: 13.60
2021 NF PE RVU: 171.52
2021 Fac PE RVU: 7.11

RUC Recommendation: 13.45 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

55875 **Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy**

Global: 090 **Issue:** RAW **Screen:** RUC request **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:**

First Identified: April 2015

2019 est Medicare Utilization: 6,399

2021 Work RVU: 13.46
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.66

RUC Recommendation: Review data at RAW

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Not Part of RAW

56515 **Destruction of lesion(s), vulva; extensive (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery)**

Global: 010 **Issue:** Destruction of Lesions **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACOG

First Identified: September 2007

2019 est Medicare Utilization: 3,187

2021 Work RVU: 3.08
2021 NF PE RVU: 4.41
2021 Fac PE RVU: 2.65

RUC Recommendation: Reduce 99238 to 0.5

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

56620 **Vulvectomy simple; partial**

Global: 090 **Issue:** Partial Removal of Vulva **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** D **Specialty Developing Recommendation:** ACOG

First Identified: September 2007

2019 est Medicare Utilization: 3,143

2021 Work RVU: 7.53
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.20

RUC Recommendation: 7.35

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

57150 **Irrigation of vagina and/or application of medicament for treatment of bacterial, parasitic, or fungoid disease**

Global: 000 **Issue:** Vaginal Treatments **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 15 **Specialty Developing Recommendation:** ACOG

First Identified: July 2016

2019 est Medicare Utilization: 24,482

2021 Work RVU: 0.50
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

57155 **Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy** **Global:** 000 **Issue:** RAW **Screen:** Site of Service Anomaly / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 3,111

2021 Work RVU: 5.15
2021 NF PE RVU: 5.80
2021 Fac PE RVU: 2.64

RUC Recommendation: 5.40 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57156 **Insertion of a vaginal radiation afterloading apparatus for clinical brachytherapy** **Global:** 000 **Issue:** RAW **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** ACOG, ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 15,369

2021 Work RVU: 2.69
2021 NF PE RVU: 3.65
2021 Fac PE RVU: 1.47

RUC Recommendation: 2.69 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

57160 **Fitting and insertion of pessary or other intravaginal support device** **Global:** 000 **Issue:** Vaginal Treatments **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 15 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2016 **2019 est Medicare Utilization:** 85,733

2021 Work RVU: 0.89
2021 NF PE RVU: 1.11
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.89 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57240 **Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele, including cystourethroscopy, when performed**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** October 2015 **2019 est Medicare Utilization:** 9,026

2021 Work RVU: 10.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.44

RUC Recommendation: 10.08 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57250 **Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 8,757

2021 Work RVU: 10.08
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.48

RUC Recommendation: 10.08 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57260 **Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed;**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 9,740

2021 Work RVU: 13.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.67

RUC Recommendation: 13.25 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57265 **Combined anteroposterior colporrhaphy, including cystourethroscopy, when performed; with enterocele repair**

Global: 090 **Issue:** Colporrhaphy with Cystourethroscopy **Screen:** Site of Service Anomaly - 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 14 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2016 **2019 est Medicare Utilization:** 4,370

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.38

RUC Recommendation: 15.00 **Referred to CPT** September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57282 **Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus)** **Global:** 090 **Issue:** Colpopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 7,042

2021 Work RVU: 11.63
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.05

RUC Recommendation: 13.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

57283 **Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy)** **Global:** 090 **Issue:** Colpopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 5,777

2021 Work RVU: 11.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.11

RUC Recommendation: 13.51 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

57287 **Removal or revision of sling for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** C **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,737

2021 Work RVU: 11.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.93

RUC Recommendation: 10.97 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

57288 **Sling operation for stress incontinence (eg, fascia or synthetic)** **Global:** 090 **Issue:** Sling Operation for Stress Incontinence **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** O **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 25,452

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.93

RUC Recommendation: 12.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

57425 **Laparoscopy, surgical, colpopexy (suspension of vaginal apex)** **Global:** 090 **Issue:** Laparoscopic Colopexy **Screen:** Site of Service Anomaly - 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 27 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 9,468

2021 Work RVU: 17.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.10

RUC Recommendation: 18.02 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

58100 **Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)** **Global:** 000 **Issue:** Biopsy of Uterus Lining **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2016 **2019 est Medicare Utilization:** 68,910

2021 Work RVU: 1.21
2021 NF PE RVU: 1.60
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.21 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

58110 **Endometrial sampling (biopsy) performed in conjunction with colposcopy (list separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Biopsy of Uterus Lining **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** April 2017 **2019 est Medicare Utilization:** 672

2021 Work RVU: 0.77
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58555 **Hysteroscopy, diagnostic (separate procedure)** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 1,494

2021 Work RVU: 2.65
2021 NF PE RVU: 7.57
2021 Fac PE RVU: 1.38

RUC Recommendation: 3.07 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58558 **Hysteroscopy, surgical; with sampling (biopsy) of endometrium and/or polypectomy, with or without d & c** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 47,694

2021 Work RVU: 4.17
2021 NF PE RVU: 38.05
2021 Fac PE RVU: 1.96

RUC Recommendation: 4.37 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58559 **Hysteroscopy, surgical; with lysis of intrauterine adhesions (any method)** **Global:** 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 121

2021 Work RVU: 5.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.35

RUC Recommendation: 5.54 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58560 **Hysteroscopy, surgical; with division or resection of intrauterine septum (any method)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 44

2021 Work RVU: 5.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.55

RUC Recommendation: 6.15 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58561 **Hysteroscopy, surgical; with removal of leiomyomata**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2015 **2019 est Medicare Utilization:** 2,396

2021 Work RVU: 6.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.89

RUC Recommendation: 7.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

58562 **Hysteroscopy, surgical; with removal of impacted foreign body**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 206

2021 Work RVU: 4.00
2021 NF PE RVU: 8.07
2021 Fac PE RVU: 1.88

RUC Recommendation: 4.17 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58563 **Hysteroscopy, surgical; with endometrial ablation (eg, endometrial resection, electrosurgical ablation, thermoablation)**

Global: 000 **Issue:** Hysteroscopy **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 37 **Specialty Developing Recommendation:** ACOG **First Identified:** NA **2019 est Medicare Utilization:** 2,831

2021 Work RVU: 4.47
2021 NF PE RVU: 59.54
2021 Fac PE RVU: 2.06

RUC Recommendation: 4.62 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

58660 **Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure)**

Global: 090 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AUA, ACOG **First Identified:** September 2007 **2019 est Medicare Utilization:** 761

2021 Work RVU: 11.59
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.43

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

58661 **Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)**

Global: 010 **Issue:** Laproscopic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ACOG **First Identified:** September 2007 **2019 est Medicare Utilization:** 13,081

2021 Work RVU: 11.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.04

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

58823 **Drainage of pelvic abscess, transvaginal or transrectal approach, percutaneous (eg, ovarian, pericolic)**

Global: **Issue:** Drainage of Abscess **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

59400 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,825

2021 Work RVU: 36.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.40

RUC Recommendation: 32.69 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59409 **Vaginal delivery only (with or without episiotomy and/or forceps);**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,615

2021 Work RVU: 14.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.67

RUC Recommendation: 14.37 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59410 **Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 823

2021 Work RVU: 18.34
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.24

RUC Recommendation: 18.54 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59412 **External cephalic version, with or without tocolysis**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 29

2021 Work RVU: 1.71
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.83

RUC Recommendation: 1.71 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

59414 **Delivery of placenta (separate procedure)**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 56

2021 Work RVU: 1.61
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.61 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

59425 **Antepartum care only; 4-6 visits**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 666

2021 Work RVU: 7.80
2021 NF PE RVU: 6.63
2021 Fac PE RVU: 3.05

RUC Recommendation: 6.31 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

59426 **Antepartum care only; 7 or more visits**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 710

2021 Work RVU: 14.30
2021 NF PE RVU: 12.14
2021 Fac PE RVU: 5.62

RUC Recommendation: 11.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59430 **Postpartum care only (separate procedure)** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 1,138

2021 Work RVU: 3.22
2021 NF PE RVU: 3.59
2021 Fac PE RVU: 1.26

RUC Recommendation: 2.47 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59510 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,365

2021 Work RVU: 40.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 26.09

RUC Recommendation: 36.17 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59514 **Cesarean delivery only;** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,266

2021 Work RVU: 16.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.25

RUC Recommendation: 16.13 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

59515 **Cesarean delivery only; including postpartum care** **Global:** MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 760

2021 Work RVU: 22.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.19

RUC Recommendation: 22.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59610 **Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 89

2021 Work RVU: 38.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 24.53

RUC Recommendation: 34.40 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59612 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps);**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 65

2021 Work RVU: 16.09
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.14

RUC Recommendation: 16.09 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59614 **Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 36

2021 Work RVU: 20.06
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.11

RUC Recommendation: 20.26 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

59618 **Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 22

2021 Work RVU: 40.91
2021 NF PE RVU: NA
2021 Fac PE RVU: 26.17

RUC Recommendation: 36.69 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

59620 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery;**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 13

2021 Work RVU: 16.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.36

RUC Recommendation: 16.66 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

59622 **Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery; including postpartum care**

Global: MMM **Issue:** Obstetrical Care **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AAFP **First Identified:** April 2008 **2019 est Medicare Utilization:** 6

2021 Work RVU: 22.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.81

RUC Recommendation: 22.53 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

60220 **Total thyroid lobectomy, unilateral; with or without isthmusectomy**

Global: 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 7,841

2021 Work RVU: 11.19
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.47

RUC Recommendation: 12.29 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

60225 **Total thyroid lobectomy, unilateral; with contralateral subtotal lobectomy, including isthmusectomy**

Global: 090 **Issue:** Total Thyroid Lobectomy **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 46 **Specialty Developing Recommendation:** ACS, AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 308

2021 Work RVU: 14.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.89

RUC Recommendation: 14.67 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

60520 **Thymectomy, partial or total; transcervical approach (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2019 est Medicare Utilization:** 437

2021 Work RVU: 17.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.81

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

60521 **Thymectomy, partial or total; sternal split or transthoracic approach, without radical mediastinal dissection (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** **First Identified:** November 2011 **2019 est Medicare Utilization:** 254

2021 Work RVU: 19.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.29

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures. **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

60522 **Thymectomy, partial or total; sternal split or transthoracic approach, with radical mediastinal dissection (separate procedure)**

Global: 090 **Issue:** RAW Review **Screen:** CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:**

First Identified: November 2011 **2019 est Medicare Utilization:** 120

2021 Work RVU: 23.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.24

RUC Recommendation: No reliable way to determine an incremental difference from open thoracotomy to thoracoscopic procedures.

Referred to CPT **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

61055 **Cisternal or lateral cervical (c1-c2) puncture; with injection of medication or other substance for diagnosis or treatment**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: January 2014 **2019 est Medicare Utilization:** 293

2021 Work RVU: 2.10
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.06

RUC Recommendation: Editorial change

Referred to CPT October 2013 **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

61781 **Stereotactic computer-assisted (navigational) procedure; cranial, intradural (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS

First Identified: October 2009 **2019 est Medicare Utilization:** 15,851

2021 Work RVU: 3.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.79

RUC Recommendation: 3.75

Referred to CPT October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61782 **Stereotactic computer-assisted (navigational) procedure; cranial, extradural (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS, AAO-HNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 18,750

2021 Work RVU: 3.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.41

RUC Recommendation: 3.18 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61783 **Stereotactic computer-assisted (navigational) procedure; spinal (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Computer-Assisted Volumetric Navigational Procedures **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 13 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 18,207

2021 Work RVU: 3.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.82

RUC Recommendation: 3.75 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61793 **Deleted from CPT**

Global: **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** AANS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61795 **Deleted from CPT** **Global:** **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** NASS, AAO-HNS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

61796 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 simple cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 6,704

2021 Work RVU: 13.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.94

RUC Recommendation: 15.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61797 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, simple (list separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 8,122

2021 Work RVU: 3.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.68

RUC Recommendation: 3.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61798 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 complex cranial lesion** **Global:** 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 3,528

2021 Work RVU: 19.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.63

RUC Recommendation: 19.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

61799 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional cranial lesion, complex (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:**

First Identified: NA

2019 est Medicare Utilization: 570

2021 Work RVU: 4.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.30

RUC Recommendation: 4.81

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61800 **Application of stereotactic headframe for stereotactic radiosurgery (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Fastest Growing, Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 16 **Specialty Developing Recommendation:**

First Identified: February 2008

2019 est Medicare Utilization: 5,499

2021 Work RVU: 2.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.41

RUC Recommendation: 2.25

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

61885 **Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array**

Global: 090 **Issue:** Vagal Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 14 **Specialty Developing Recommendation:** AANS/CNS

First Identified: September 2007

2019 est Medicare Utilization: 5,787

2021 Work RVU: 6.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.30

RUC Recommendation: 6.44

Referred to CPT October 2009

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62263 **Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days**

Global: 010 **Issue:** Epidual Lysis **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 66 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 302

2021 Work RVU: 5.00
2021 NF PE RVU: 13.40
2021 Fac PE RVU: 3.59

RUC Recommendation: 6.54 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

62270 **Spinal puncture, lumbar, diagnostic;**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** ACR, ASNR, SIR **First Identified:** October 2017 **2019 est Medicare Utilization:** 79,126

2021 Work RVU: 1.22
2021 NF PE RVU: 2.50
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.44 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

62272 **Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 6,301

2021 Work RVU: 1.58
2021 NF PE RVU: 3.31
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.80 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62281 **Injection/infusion of neurolytic substance (eg, alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic**

Global: 010 **Issue:** Injection of Neurolytic Agent **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 390

2021 Work RVU: 2.66
2021 NF PE RVU: 4.32
2021 Fac PE RVU: 1.76

RUC Recommendation: Remove 99238 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Q&A May 2010

62284 **Injection procedure for myelography and/or computed tomography, lumbar**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 16,213

2021 Work RVU: 1.54
2021 NF PE RVU: 4.18
2021 Fac PE RVU: 0.77

RUC Recommendation: 1.54 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

62287 **Decompression procedure, percutaneous, of nucleus pulposus of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar**

Global: 090 **Issue:** Percutaneous Diskectomy **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 166

2021 Work RVU: 9.03
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.85

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62290 **Injection procedure for discography, each level; lumbar**

Global: 000 **Issue:** Injection for discography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, AUR, NASS, ACR, ASNR, ISIS, AANS **First Identified:** October 2009 **2019 est Medicare Utilization:** 7,115

2021 Work RVU: 3.00
2021 NF PE RVU: 7.65
2021 Fac PE RVU: 1.51

RUC Recommendation: 3.00, CPT Assistant article published.

Referred to CPT **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2011

62302 **Myelography via lumbar injection, including radiological supervision and interpretation; cervical**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 4,191

2021 Work RVU: 2.29
2021 NF PE RVU: 5.30
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.29

Referred to CPT October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62303 **Myelography via lumbar injection, including radiological supervision and interpretation; thoracic**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 411

2021 Work RVU: 2.29
2021 NF PE RVU: 5.43
2021 Fac PE RVU: 1.00

RUC Recommendation: 2.29

Referred to CPT October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62304 **Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 18,417

2021 Work RVU: 2.25
2021 NF PE RVU: 5.25
2021 Fac PE RVU: 0.99

RUC Recommendation: 2.25 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62305 **Myelography via lumbar injection, including radiological supervision and interpretation; 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical)**

Global: 000 **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 6,616

2021 Work RVU: 2.35
2021 NF PE RVU: 5.82
2021 Fac PE RVU: 1.03

RUC Recommendation: 2.35 **Referred to CPT** October 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62310 **Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62311 **Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

62318 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

62319 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)**

Global: **Issue:** Epidural Injections **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, ISIS, NASS, ASNR, ASIPP **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62320 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 5,631

2021 Work RVU: 1.80
2021 NF PE RVU: 2.89
2021 Fac PE RVU: 0.87

RUC Recommendation: 1.80 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62321 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or ct)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 217,240

2021 Work RVU: 1.95
2021 NF PE RVU: 5.82
2021 Fac PE RVU: 1.00

RUC Recommendation: 1.95 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62322 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 42,693

2021 Work RVU: 1.55
2021 NF PE RVU: 2.55
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.55 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62323 **Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or ct)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 699,990

2021 Work RVU: 1.80
2021 NF PE RVU: 5.88
2021 Fac PE RVU: 0.92

RUC Recommendation: 1.80 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62324 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 19,559

2021 Work RVU: 1.89
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.56

RUC Recommendation: 1.89 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62325 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or ct)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 1,225

2021 Work RVU: 2.20
2021 NF PE RVU: 5.21
2021 Fac PE RVU: 0.82

RUC Recommendation: 2.20 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62326 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 4,644

2021 Work RVU: 1.78
2021 NF PE RVU: 2.31
2021 Fac PE RVU: 0.58

RUC Recommendation: 1.78 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62327 **Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or ct)**

Global: 000 **Issue:** Epidural Injections **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 10 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** May 2015 **2019 est Medicare Utilization:** 1,995

2021 Work RVU: 1.90
2021 NF PE RVU: 5.78
2021 Fac PE RVU: 0.92

RUC Recommendation: 1.90 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62328 **Spinal puncture, lumbar, diagnostic; with fluoroscopic or ct guidance**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.73
2021 NF PE RVU: 5.71
2021 Fac PE RVU: 0.62

RUC Recommendation: 1.95 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

62329 **Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or ct guidance**

Global: 000 **Issue:** Lumbar Puncture **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.03
2021 NF PE RVU: 7.22
2021 Fac PE RVU: 0.82

RUC Recommendation: 2.25 **Referred to CPT** September 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62350 **Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 5,884

2021 Work RVU: 6.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.53

RUC Recommendation: 6.05 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62355 **Removal of previously implanted intrathecal or epidural catheter**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,056

2021 Work RVU: 3.55
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.71

RUC Recommendation: 4.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62360 **Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** April 2008 **2019 est Medicare Utilization:** 242

2021 Work RVU: 4.33
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.12

RUC Recommendation: 4.33 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62361 **Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** April 2008 **2019 est Medicare Utilization:** 36

2021 Work RVU: 5.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.90

RUC Recommendation: 5.65 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62362 **Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 8,146

2021 Work RVU: 5.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.53

RUC Recommendation: 6.10 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62365 **Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion**

Global: 010 **Issue:** Intrathecal Epidural Catheters & Pumps **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 67 **Specialty Developing Recommendation:** AAPMR, ASA, NASS, AAPM, AANS/CNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,266

2021 Work RVU: 3.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.88

RUC Recommendation: 4.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

62367 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2009 **2019 est Medicare Utilization:** 10,982

2021 Work RVU: 0.48
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.19

RUC Recommendation: New PE inputs. 0.48 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

62368 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2009 **2019 est Medicare Utilization:** 43,410

2021 Work RVU: 0.67
2021 NF PE RVU: 0.55
2021 Fac PE RVU: 0.27

RUC Recommendation: New PE inputs. 0.67 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62369 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2010 **2019 est Medicare Utilization:** 31,581

2021 Work RVU: 0.67
2021 NF PE RVU: 2.09
2021 Fac PE RVU: 0.28

RUC Recommendation: New PE inputs. 0.67 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

62370 **Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming and refill (requiring skill of a physician or other qualified health care professional)**

Global: XXX **Issue:** Electronic Analysis Implanted Pump (PE Only) **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 14 **Specialty Developing Recommendation:** AAPM, AAPMR, ASA, SIS **First Identified:** October 2010 **2019 est Medicare Utilization:** 101,707

2021 Work RVU: 0.90
2021 NF PE RVU: 1.90
2021 Fac PE RVU: 0.36

RUC Recommendation: New PE inputs. 1.10 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63020 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical**

Global: 090 **Issue:** Lumbar Laminotomy with Decompression **Screen:** Site of Service Anomaly - 2018 **Complete?** No

Most Recent RUC Meeting: January 2022 **Tab:** **Specialty Developing Recommendation:** AAOS, ISASS, NASS **First Identified:** January 2022 **2019 est Medicare Utilization:** 1,345

2021 Work RVU: 16.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.17

RUC Recommendation: Survey **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

63030 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar**

Global: 090 **Issue:** Lumbar Laminotomy with Decompression **Screen:** Pre-Time Analysis / Site of Service Anomaly - 2018 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** January 2014 **2019 est Medicare Utilization:** 27,404

2021 Work RVU: 13.18
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.67

RUC Recommendation: Survey **Referred to CPT** September 2021 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

63035 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Lumbar Laminotomy with Decompression **Screen:** Site of Service Anomaly - 2018 **Complete?** No

Most Recent RUC Meeting: January 2022 **Tab:** **Specialty Developing Recommendation:** AANS, AAOS, CNS, ISASS, NASS **First Identified:** January 2022 **2019 est Medicare Utilization:** 6,873

2021 Work RVU: 3.15
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.56

RUC Recommendation: Survey **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63042 **Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar**

Global: 090 **Issue:** RAW **Screen:** Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** AANS, AAOS, NASS **First Identified:** January 2014 **2019 est Medicare Utilization:** 10,851

2021 Work RVU: 18.76
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.29

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 4.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63045 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical**

Global: 090 **Issue:** Laminectomy **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 16 **Specialty Developing Recommendation:** **First Identified:** November 2013 **2019 est Medicare Utilization:** 10,977

2021 Work RVU: 17.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.22

RUC Recommendation: 17.95

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63046 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic**

Global: 090 **Issue:** Laminectomy **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 16 **Specialty Developing Recommendation:** **First Identified:** November 2013 **2019 est Medicare Utilization:** 4,057

2021 Work RVU: 17.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.73

RUC Recommendation: 17.25

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63047 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar**

Global: 090 **Issue:** Laminectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 24 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** September 2011 **2019 est Medicare Utilization:** 101,838

2021 Work RVU: 15.37
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.73

RUC Recommendation: 15.37 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63048 **Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional vertebral segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Laminectomy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 24 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** January 2012 **2019 est Medicare Utilization:** 128,927

2021 Work RVU: 3.47
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.72

RUC Recommendation: 3.47 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63056 **Transpedicular approach with decompression of spinal cord, equina and/or nerve root(s) (eg, herniated intervertebral disc), single segment; lumbar (including transfacet, or lateral extraforaminal approach) (eg, far lateral herniated intervertebral disc)**

Global: 090 **Issue:** RAW **Screen:** CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 6,048

2021 Work RVU: 21.86
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.52

RUC Recommendation: Review action plan at RAW Oct 2015. Maintain **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009

Status Report: CMS Requests and Relativity Assessment Issues

63075 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, single interspace**

Global: 090 **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 428

2021 Work RVU: 19.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.62

RUC Recommendation: 19.60 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63076 **Discectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophytectomy; cervical, each additional interspace (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Arthrodesis Including Discectomy **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 5 **Specialty Developing Recommendation:** NASS, AANS/CNS **First Identified:** **2019 est Medicare Utilization:** 313

2021 Work RVU: 4.04
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.99

RUC Recommendation: 4.04 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63090 **Vertebral corpectomy (vertebral body resection), partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment**

Global: 090 **Issue:** Vertebral Corpectomy with Arthrodesis **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** No

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, AANS **First Identified:** January 2015 **2019 est Medicare Utilization:** 719

2021 Work RVU: 30.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 19.02

RUC Recommendation: Review action plan and additional data **Referred to CPT** September 2016 **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63620 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion**

Global: 090 **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:**

First Identified: NA

2019 est Medicare Utilization: 492

2021 Work RVU: 15.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.77

RUC Recommendation: 15.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

63621 **Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Stereotactic Radiosurgery **Screen:** CMS Request - 2009 Final Rule **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:**

First Identified: NA

2019 est Medicare Utilization: 160

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.92

RUC Recommendation: 4.00

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

63650 **Percutaneous implantation of neurostimulator electrode array, epidural**

Global: 010 **Issue:** Percutaneous implantation of neurostimulator **Screen:** Site of Service Anomaly / CMS Fastest Growing / CMS Request - Final Rule for 2013 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS

First Identified: September 2007

2019 est Medicare Utilization: 92,083

2021 Work RVU: 7.15
2021 NF PE RVU: 58.56
2021 Fac PE RVU: 4.24

RUC Recommendation: 7.20. New PE Inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

63655 **Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** NASS, AANS **First Identified:** October 2008 **2019 est Medicare Utilization:** 8,801

2021 Work RVU: 10.92
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.29

RUC Recommendation: 11.43 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

63660 **Deleted from CPT**

Global: **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

63661 **Removal of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed**

Global: 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:** 3,832

2021 Work RVU: 5.08
2021 NF PE RVU: 14.23
2021 Fac PE RVU: 3.61

RUC Recommendation: 5.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63662 **Removal of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:** 2,414

2021 Work RVU: 11.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.47

RUC Recommendation: 10.87 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63663 **Revision including replacement, when performed, of spinal neurostimulator electrode percutaneous array(s), including fluoroscopy, when performed**

Global: 010 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:** 1,584

2021 Work RVU: 7.75
2021 NF PE RVU: 17.85
2021 Fac PE RVU: 4.47

RUC Recommendation: 70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63664 **Revision including replacement, when performed, of spinal neurostimulator electrode plate/paddle(s) placed via laminotomy or laminectomy, including fluoroscopy, when performed**

Global: 090 **Issue:** Neurostimulator (Spinal) **Screen:** Site of Service Anomaly / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 17 **Specialty Developing Recommendation:** ISIS, NASS, AANS/CNS, ASA, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:** 692

2021 Work RVU: 11.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.73

RUC Recommendation: 11.39 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

63685 **Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly / CMS Fastest Growing/ High Volume Growth7 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 29,921

2021 Work RVU: 5.19
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.42

RUC Recommendation: Review action plan in 2 years after CPT article published. 6.05 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

63688 **Revision or removal of implanted spinal neurostimulator pulse generator or receiver**

Global: 010 **Issue:** Neurostimulators **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** I **Specialty Developing Recommendation:** AAPM, AANS/CNS, ASA, ISIS, NASS **First Identified:** September 2007 **2019 est Medicare Utilization:** 8,593

2021 Work RVU: 5.30
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.54

RUC Recommendation: 5.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64400 **Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)**

Global: 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAN, AAPM&R, AAPM, NANS, SIS **First Identified:** October 2021 **2019 est Medicare Utilization:** 36,483

2021 Work RVU: 0.75
2021 NF PE RVU: 2.40
2021 Fac PE RVU: 0.53

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64405 **Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve**

Global: 000 **Issue:** Somatic Nerve Injections **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAN, AAPM, AAPM&R, NANS, SIS **First Identified:** July 2016 **2019 est Medicare Utilization:** 134,871

2021 Work RVU: 0.94
2021 NF PE RVU: 1.04
2021 Fac PE RVU: 0.42

RUC Recommendation: 0.94 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

64408 **Injection(s), anesthetic agent(s) and/or steroid; vagus nerve**

Global: 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, NANS, SIS **First Identified:** October 2021 **2019 est Medicare Utilization:** 538

2021 Work RVU: 0.75
2021 NF PE RVU: 1.44
2021 Fac PE RVU: 0.43

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64412 **Injection, anesthetic agent; spinal accessory nerve** **Global:** **Issue:** Anesthetic Injection – Spinal Nerve **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 36 **Specialty Developing Recommendation:** AAN, ASA, AAPMR, ISIS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** FAQ Sept 2015

64415 **Injection(s), anesthetic agent(s) and/or steroid; brachial plexus** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 199,150

2021 Work RVU: 1.35
2021 NF PE RVU: 1.89
2021 Fac PE RVU: 0.38

RUC Recommendation: 1.50 **Referred to CPT** May 2021 **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

64416 **Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Site of Service Anomaly / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** September 2007 **2019 est Medicare Utilization:** 17,912

2021 Work RVU: 1.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.27

RUC Recommendation: 1.80 **Referred to CPT** May 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64417 **Injection(s), anesthetic agent(s) and/or steroid; axillary nerve** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** part of New/Revised Review **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2018 **2019 est Medicare Utilization:** 15,765

2021 Work RVU: 1.27
2021 NF PE RVU: 2.76
2021 Fac PE RVU: 0.39

RUC Recommendation: 1.31 **Referred to CPT** May 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64418 **Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, SIS **First Identified:** October 2015 **2019 est Medicare Utilization:** 31,818

2021 Work RVU: 1.10
2021 NF PE RVU: 1.38
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.10 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64420 **Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, NANS, SIS **First Identified:** October 2021 **2019 est Medicare Utilization:** 3,812

2021 Work RVU: 1.08
2021 NF PE RVU: 1.75
2021 Fac PE RVU: 0.54

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

64421 **Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (list separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, NANS, SIS **First Identified:** October 2021 **2019 est Medicare Utilization:** 18,541

2021 Work RVU: 0.50
2021 NF PE RVU: 0.44
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64425 **Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, NANS, SIS **First Identified:** October 2021 **2019 est Medicare Utilization:** 7,963

2021 Work RVU: 1.00
2021 NF PE RVU: 2.27
2021 Fac PE RVU: 0.51

RUC Recommendation: 1.19 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64430 **Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ACOG, NANS, SIS **First Identified:** October 2021 **2019 est Medicare Utilization:** 4,007

2021 Work RVU: 1.00
2021 NF PE RVU: 1.73
2021 Fac PE RVU: 0.48

RUC Recommendation: 1.15 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64435 **Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ACOG, NANS, SIS **First Identified:** October 2021 **2019 est Medicare Utilization:** 38

2021 Work RVU: 0.75
2021 NF PE RVU: 1.47
2021 Fac PE RVU: 0.40

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64445 **Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 130,719

2021 Work RVU: 1.00
2021 NF PE RVU: 2.68
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.39 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

64446 **Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Site of Service Anomaly / High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,880

2021 Work RVU: 1.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.25

RUC Recommendation: 1.75 **Referred to CPT** May 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64447 **Injection(s), anesthetic agent(s) and/or steroid; femoral nerve** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** October 2008 **2019 est Medicare Utilization:** 282,703

2021 Work RVU: 1.10
2021 NF PE RVU: 1.45
2021 Fac PE RVU: 0.35

RUC Recommendation: 1.34 **Referred to CPT** May 2021 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & Apr 2012

64448 **Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Site of Service Anomaly / High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 40,188

2021 Work RVU: 1.41
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.25

RUC Recommendation: 1.68 **Referred to CPT** May 2021 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

64449 **Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, NANS, SIS **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,957

2021 Work RVU: 1.27
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.55 **Referred to CPT** February 2008 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64450 **Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Harvard Valued - Utilization over 100,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million / High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, APMA, NANS, SIS **First Identified:** October 2009 **2019 est Medicare Utilization:** 467,316

2021 Work RVU: 0.75
2021 NF PE RVU: 1.45
2021 Fac PE RVU: 0.40

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2013

64451 **Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, NANS, SIS **First Identified:** October 2021 **2019 est Medicare Utilization:**

2021 Work RVU: 1.52
2021 NF PE RVU: 4.91
2021 Fac PE RVU: 0.63

RUC Recommendation: 1.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

64454 **Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed** **Global:** 000 **Issue:** Somatic Nerve Injections **Screen:** Added as part of family **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, NANS, SIS **First Identified:** October 2021 **2019 est Medicare Utilization:**

2021 Work RVU: 1.52
2021 NF PE RVU: 4.89
2021 Fac PE RVU: 0.71

RUC Recommendation: 1.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64455 **Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, morton's neuroma)**

Global: 000 **Issue:** Somatic Nerve Injections **Screen:** High Volume Growth4 / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, APMA, NANS, SIS **First Identified:** October 2016 **2019 est Medicare Utilization:** 74,450

2021 Work RVU: 0.75
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

64461 **Paravertebral block (pvb) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)**

Global: 000 **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 4,096

2021 Work RVU: 1.75
2021 NF PE RVU: 2.05
2021 Fac PE RVU: 0.35

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

64462 **Paravertebral block (pvb) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,483

2021 Work RVU: 1.10
2021 NF PE RVU: 0.99
2021 Fac PE RVU: 0.24

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

Status Report: CMS Requests and Relativity Assessment Issues

64463 **Paravertebral block (pvb) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)**

Global: 000 **Issue:** Paravertebral Block Injection **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 10 **Specialty Developing Recommendation:** ASA **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,514

2021 Work RVU: 1.90
2021 NF PE RVU: 4.59
2021 Fac PE RVU: 0.35

RUC Recommendation: CPT Assistant article published Jan 2016 **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

64470 **Deleted from CPT**

Global: **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64472 **Deleted from CPT**

Global: **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64475 **Deleted from CPT**

Global: **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64476 **Deleted from CPT** **Global:** **Issue:** Injection Anesthetic Agent **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64479 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or ct), cervical or thoracic, single level** **Global:** 000 **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 44,367

2021 Work RVU: 2.29
2021 NF PE RVU: 5.38
2021 Fac PE RVU: 1.32

RUC Recommendation: 2.29 **Referred to CPT** June 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

64480 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or ct), cervical or thoracic, each additional level (list separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Injection Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 19,219

2021 Work RVU: 1.20
2021 NF PE RVU: 2.66
2021 Fac PE RVU: 0.49

RUC Recommendation: 1.20 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64483 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or ct), lumbar or sacral, single level** **Global:** 000 **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,044,547

2021 Work RVU: 1.90
2021 NF PE RVU: 5.26
2021 Fac PE RVU: 1.18

RUC Recommendation: 1.90 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64484 **Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or ct), lumbar or sacral, each additional level (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Injection of Anesthetic Agent **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, ISIS, ASA, NASS, AAPMR **First Identified:** October 2008 **2019 est Medicare Utilization:** 431,178

2021 Work RVU: 1.00
2021 NF PE RVU: 2.19
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.00 **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64490 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), cervical or thoracic; single level**

Global: 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 265,103

2021 Work RVU: 1.82
2021 NF PE RVU: 3.71
2021 Fac PE RVU: 1.08

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64491 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), cervical or thoracic; second level (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 239,462

2021 Work RVU: 1.16
2021 NF PE RVU: 1.60
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64492 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), cervical or thoracic; third and any additional level(s) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 156,746

2021 Work RVU: 1.16
2021 NF PE RVU: 1.61
2021 Fac PE RVU: 0.50

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64493 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), lumbar or sacral; single level**

Global: 000 **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 901,171

2021 Work RVU: 1.52
2021 NF PE RVU: 3.58
2021 Fac PE RVU: 0.97

RUC Recommendation: 1.52 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64494 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), lumbar or sacral; second level (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 809,666

2021 Work RVU: 1.00
2021 NF PE RVU: 1.59
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64495 **Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or ct), lumbar or sacral; third and any additional level(s) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Facet Joint Injections **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 18 **Specialty Developing Recommendation:** ASA, NASS, ASNR, AAPMR, AANS/CNS, AAPM, ISIS **First Identified:** **2019 est Medicare Utilization:** 456,363

2021 Work RVU: 1.00
2021 NF PE RVU: 1.59
2021 Fac PE RVU: 0.43

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64510 **Injection, anesthetic agent; stellate ganglion (cervical sympathetic)**

Global: 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2019 est Medicare Utilization:** 6,436

2021 Work RVU: 1.22
2021 NF PE RVU: 3.00
2021 Fac PE RVU: 0.90

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

64520 **Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)**

Global: 000 **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2009 **2019 est Medicare Utilization:** 18,919

2021 Work RVU: 1.35
2021 NF PE RVU: 5.34
2021 Fac PE RVU: 0.97

RUC Recommendation: PE Review - no change **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64550 **Application of surface (transcutaneous) neurostimulator (eg, TENS unit)** **Global:** **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** AANS, CNS, AOTA **First Identified:** January 2017 **2019 est Medicare Utilization:** **2021 Work RVU:** **2021 NF PE RVU:** **2021 Fac PE RVU:**

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64553 **Percutaneous implantation of neurostimulator electrode array; cranial nerve** **Global:** 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 15 **Specialty Developing Recommendation:** AANS, CNS, ASA **First Identified:** July 2014 **2019 est Medicare Utilization:** 484 **2021 Work RVU:** 6.13 **2021 NF PE RVU:** 64.69 **2021 Fac PE RVU:** 3.71

RUC Recommendation: 6.13 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

64555 **Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)** **Global:** 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** High Volume Growth1 / CMS Fastest Growing / Final Rule for 2015 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AANS, CNS, ASA **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,342 **2021 Work RVU:** 5.76 **2021 NF PE RVU:** 58.65 **2021 Fac PE RVU:** 3.42

RUC Recommendation: 5.76. Article published Jan2016 and addressed issues. **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2016

Status Report: CMS Requests and Relativity Assessment Issues

64561 **Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed**

Global: 010 **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** CMS Fastest Growing / High Volume Growth2 / High Level E/M in Global Period / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** AANS, CNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 14,987

2021 Work RVU: 5.44
2021 NF PE RVU: 16.70
2021 Fac PE RVU: 2.74

RUC Recommendation: 5.44. 99214 visit appropriate. Remove from screen.

Referred to CPT September 2016 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64565 **Percutaneous implantation of neurostimulator electrode array; neuromuscular**

Global: **Issue:** Percutaneous NeurostimulatorPlacement **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 15 **Specialty Developing Recommendation:** AANS, CNS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

64566 **Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming**

Global: 000 **Issue:** Posterior Tibial Neurostimulation **Screen:** CMS Request - Final Rule for 2014 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** July 2013 **2019 est Medicare Utilization:** 201,680

2021 Work RVU: 0.60
2021 NF PE RVU: 3.05
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.60

Referred to CPT **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64568 **Open implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator**

Global: 090 **Issue:** Vagus Nerve Stimulator **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 14 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,002

2021 Work RVU: 9.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.98

RUC Recommendation: 11.19 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

64573 **Deleted from CPT**

Global: **Issue:** Neurosurgical Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 28 **Specialty Developing Recommendation:** AANS/CNS **First Identified:** September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64581 **Open implantation of neurostimulator electrode array; sacral nerve (transforaminal placement)**

Global: 090 **Issue:** Urological Procedures **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** AUA **First Identified:** September 2007 **2019 est Medicare Utilization:** 10,284

2021 Work RVU: 12.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 5.51

RUC Recommendation: 12.20. 99214 visit appropriate. Remove from screen. **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64590 **Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling**

Global: 010 **Issue:** RAW **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** ACOG, AUA **First Identified:** October 2012 **2019 est Medicare Utilization:** 12,197

2021 Work RVU: 2.45
2021 NF PE RVU: 5.24
2021 Fac PE RVU: 1.92

RUC Recommendation:

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

64615 **Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)**

Global: 010 **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** AAN, AANEM, AAPM&R, NANS **First Identified:** October 2019 **2019 est Medicare Utilization:** 143,888

2021 Work RVU: 1.85
2021 NF PE RVU: 2.08
2021 Fac PE RVU: 1.18

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

64622 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level**

Global: **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: PE Review - no change

Referred to CPT June 2008 and Feb 2011
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

64623 **Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, each additional level (List separately in addition to code for primary procedure)**

Global: **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth1, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64626 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, single level**

Global: **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review, High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ASA, ISIS, AAPM, APM&R **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: PE Review - no change **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

64627 **Destruction by neurolytic agent, paravertebral facet joint nerve; cervical or thoracic, each additional level (List separately in addition to code for primary procedure)**

Global: **Issue:** Destruction by Neurolytic Agent **Screen:** High Volume Growth1/ CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** ASA, NASS, AAPM **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2008 and Feb 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64633 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); cervical or thoracic, single facet joint**

Global: 010 **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 86,013

2021 Work RVU: 3.84
2021 NF PE RVU: 8.33
2021 Fac PE RVU: 2.35

RUC Recommendation: 3.42 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

64634 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); cervical or thoracic, each additional facet joint (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 135,589

2021 Work RVU: 1.32
2021 NF PE RVU: 4.21
2021 Fac PE RVU: 0.53

RUC Recommendation: 1.32 **Referred to CPT** May 2015 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

64635 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); lumbar or sacral, single facet joint**

Global: 010 **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 358,450

2021 Work RVU: 3.78
2021 NF PE RVU: 8.28
2021 Fac PE RVU: 2.33

RUC Recommendation: 3.42 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2015

Status Report: CMS Requests and Relativity Assessment Issues

64636 **Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or ct); lumbar or sacral, each additional facet joint (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Destruction by Neurolytic Agent **Screen:** Work Neutrality Review **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 17 **Specialty Developing Recommendation:** ASA, AAPM, AAPMR, ASIPP, ISIS, NANS, NASS, SIS **First Identified:** September 2014 **2019 est Medicare Utilization:** 539,040

2021 Work RVU: 1.16
2021 NF PE RVU: 3.89
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.16 **Referred to CPT** May 2015 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2015

64640 **Destruction by neurolytic agent; other peripheral nerve or branch**

Global: 010 **Issue:** Injection Treatment of Nerve **Screen:** Site of Service Anomaly (99238-Only) / Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 25 **Specialty Developing Recommendation:** ASAM AAPM, APMA, ASIPP **First Identified:** September 2007 **2019 est Medicare Utilization:** 184,562

2021 Work RVU: 1.98
2021 NF PE RVU: 5.34
2021 Fac PE RVU: 1.29

RUC Recommendation: 1.23. Remove 99238. **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

64708 **Neuroplasty, major peripheral nerve, arm or leg, open; other than specified**

Global: 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 69 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,356

2021 Work RVU: 6.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.44

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

64712 **Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve** **Global:** 090 **Issue:** Neuroplasty – Leg or Arm **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** AOFAS, ASSH, AAOS, ASPS **First Identified:** September 2007 **2019 est Medicare Utilization:** 705

2021 Work RVU: 8.07
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.85

RUC Recommendation: Remove from screen **Referred to CPT** February 2010 **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

64831 **Suture of digital nerve, hand or foot; 1 nerve** **Global:** 090 **Issue:** Neurorrhaphy – Finger **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 70 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** September 2007 **2019 est Medicare Utilization:** 878

2021 Work RVU: 9.16
2021 NF PE RVU: NA
2021 Fac PE RVU: 9.58

RUC Recommendation: 9.16 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

65105 **Enucleation of eye; with implant, muscles attached to implant** **Global:** 090 **Issue:** Ophthalmologic Procedures **Screen:** Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 835

2021 Work RVU: 9.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.80

RUC Recommendation: Reduce 99238 to 0.5 **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

65205 **Removal of foreign body, external eye; conjunctival superficial** **Global:** 000 **Issue:** Removal of Foreign Body - Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** July 2016 **2019 est Medicare Utilization:** 26,275

2021 Work RVU: 0.49
2021 NF PE RVU: 0.33
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65210 **Removal of foreign body, external eye; conjunctival embedded (includes concretions), subconjunctival, or scleral nonperforating**

Global: 000 **Issue:** Removal of Foreign Body - Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** July 2016 **2019 est Medicare Utilization:** 25,202

2021 Work RVU: 0.61
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.41

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

65222 **Removal of foreign body, external eye; corneal, with slit lamp**

Global: 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 26 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2019 est Medicare Utilization:** 24,544

2021 Work RVU: 0.84
2021 NF PE RVU: 1.09
2021 Fac PE RVU: 0.58

RUC Recommendation: 0.93 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

65285 **Repair of laceration; cornea and/or sclera, perforating, with reposition or resection of uveal tissue**

Global: 090 **Issue:** Repair of Eye Wound **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 8 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 704

2021 Work RVU: 15.36
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.46

RUC Recommendation: 16.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65780 **Ocular surface reconstruction; amniotic membrane transplantation, multiple layers**

Global: 090 **Issue:** Ocular Reconstruction Transplant **Screen:** CMS Fastest Growing / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 31 **Specialty Developing Recommendation:** AAO **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,974

2021 Work RVU: 7.81
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.94

RUC Recommendation: 8.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2009

65800 **Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous**

Global: 000 **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 21 **Specialty Developing Recommendation:** AAO **First Identified:** September 2011 **2019 est Medicare Utilization:** 20,137

2021 Work RVU: 1.53
2021 NF PE RVU: 1.82
2021 Fac PE RVU: 0.95

RUC Recommendation: 1.53 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

65805 **Paracentesis of anterior chamber of eye (separate procedure); with therapeutic release of aqueous**

Global: **Issue:** Paracentesis of the Eye **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 21 **Specialty Developing Recommendation:** AAO **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

65855 **Trabeculoplasty by laser surgery**

Global: 010 **Issue:** Trabeculoplasty by Laser Surgery **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 11 **Specialty Developing Recommendation:** AAO

First Identified: January 2014 **2019 est Medicare Utilization:** 143,167

2021 Work RVU: 3.00
2021 NF PE RVU: 3.96
2021 Fac PE RVU: 2.71

RUC Recommendation: 3.00 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66170 **Fistulization of sclera for glaucoma; trabeculectomy ab externo in absence of previous surgery**

Global: 090 **Issue:** Glaucoma Surgery **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 32 **Specialty Developing Recommendation:** AAO

First Identified: January 2014 **2019 est Medicare Utilization:** 6,957

2021 Work RVU: 13.94
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.61

RUC Recommendation: 13.94 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66172 **Fistulization of sclera for glaucoma; trabeculectomy ab externo with scarring from previous ocular surgery or trauma (includes injection of antifibrotic agents)**

Global: 090 **Issue:** Glaucoma Surgery **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 32 **Specialty Developing Recommendation:** AAO

First Identified: January 2014 **2019 est Medicare Utilization:** 3,104

2021 Work RVU: 14.84
2021 NF PE RVU: NA
2021 Fac PE RVU: 18.54

RUC Recommendation: 14.81 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66174 **Transluminal dilation of aqueous outflow canal; without retention of device or stent**

Global: 090 **Issue:** Dilation of Aqueous Outflow Canal **Screen:** New Technology/ New Service **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAO

First Identified: April 2010 **2019 est Medicare Utilization:** 10,214

2021 Work RVU: 12.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.35

RUC Recommendation: 8.53 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66175 **Transluminal dilation of aqueous outflow canal; with retention of device or stent** **Global:** 090 **Issue:** Dilation of Aqueous Outflow Cana **Screen:** New Technology/ New Service **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAO **First Identified:** October 2020 **2019 est Medicare Utilization:** 223

2021 Work RVU: 13.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.88

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

66179 **Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft** **Global:** 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 802

2021 Work RVU: 14.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.15

RUC Recommendation: 14.00 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

66180 **Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft** **Global:** 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 10,715

2021 Work RVU: 15.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.76

RUC Recommendation: Maintain. 15.00 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66183 **Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 4,674

2021 Work RVU: 13.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.57

RUC Recommendation: Maintain. 13.20 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

66184 **Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 594

2021 Work RVU: 9.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.53

RUC Recommendation: 9.58 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

66185 **Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft**

Global: 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million / 090-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,600

2021 Work RVU: 10.58
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.16

RUC Recommendation: Maintain. 10.58 **Referred to CPT** October 2013 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66711 **Ciliary body destruction; cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2017 **2019 est Medicare Utilization:** 7,616

2021 Work RVU: 5.62
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.58

RUC Recommendation: 6.36 **Referred to CPT** May 2018 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66761 **Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (per session)**

Global: 010 **Issue:** Iridotomy **Screen:** High IWPUT / 010-Day Global Post-Operative Visits2 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 67,836

2021 Work RVU: 3.00
2021 NF PE RVU: 5.56
2021 Fac PE RVU: 3.60

RUC Recommendation: Maintain. 3.00 **Referred to CPT** February 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66821 **Discission of secondary membranous cataract (opacified posterior lens capsule and/or anterior hyaloid); laser surgery (eg, yag laser) (1 or more stages)**

Global: 090 **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:** AAO **First Identified:** October 2010 **2019 est Medicare Utilization:** 685,933

2021 Work RVU: 3.42
2021 NF PE RVU: 6.06
2021 Fac PE RVU: 5.36

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66982 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High IWPUT / CMS Fastest Growing, Site of Service Anomaly (99238-Only) / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 159,924

2021 Work RVU: 10.25
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.53

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2009

66983 **Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 11 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 93

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Contractor Price

Referred to CPT Asst ☐ **Published in CPT Asst:**

66984 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High IWPUT / MPC List / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,694,951

2021 Work RVU: 7.35
2021 NF PE RVU: NA
2021 Fac PE RVU: 7.83

RUC Recommendation: 7.35 **Referred to CPT** May 2018 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66987 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 13.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66988 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation**

Global: 090 **Issue:** Cyclophotocoagulation **Screen:** Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 11 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 10.25 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

66989 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more**

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 12.13 **Referred to CPT** October 2020 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

66991 **Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more**

Global: **Issue:** Cataract Removal with Drainage Device Insertion **Screen:** High Volume Category III Codes **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 16 **Specialty Developing Recommendation:** AAO **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 9.23 **Referred to CPT** October 2020 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67028 **Intravitreal injection of a pharmacologic agent (separate procedure)**

Global: 000 **Issue:** Treatment of Retinal Lesion **Screen:** High Volume Growth1 / CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 14 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,868,836

2021 Work RVU: 1.44
2021 NF PE RVU: 1.75
2021 Fac PE RVU: 1.11

RUC Recommendation: 1.44 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67036 **Vitrectomy, mechanical, pars plana approach;**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 18,016

2021 Work RVU: 12.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 12.84

RUC Recommendation: 12.13 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67038 **Deleted from CPT**

Global: **Issue:** Ophthalmological Procedures **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: September 2007 **Tab:** 16 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2007 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

67039 **Vitrectomy, mechanical, pars plana approach; with focal endolaser photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 3,357

2021 Work RVU: 13.20
2021 NF PE RVU: NA
2021 Fac PE RVU: 13.50

RUC Recommendation: 13.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67040 **Vitrectomy, mechanical, pars plana approach; with endolaser panretinal photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Site of Service Anomaly (99238-Only) / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 8,666

2021 Work RVU: 14.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 14.31

RUC Recommendation: 14.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67041 **Vitrectomy, mechanical, pars plana approach; with removal of preretinal cellular membrane (eg, macular pucker)**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 13,146

2021 Work RVU: 16.33
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.44

RUC Recommendation: 16.33 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67042 **Vitrectomy, mechanical, pars plana approach; with removal of internal limiting membrane of retina (eg, for repair of macular hole, diabetic macular edema), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil)**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 26,972

2021 Work RVU: 16.33
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.44

RUC Recommendation: 16.33 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67043 **Vitrectomy, mechanical, pars plana approach; with removal of subretinal membrane (eg, choroidal neovascularization), includes, if performed, intraocular tamponade (ie, air, gas or silicone oil) and laser photocoagulation**

Global: 090 **Issue:** Vitrectomy **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 11 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 373

2021 Work RVU: 17.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 16.10

RUC Recommendation: 17.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67101 **Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy**

Global: 010 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2015 **2019 est Medicare Utilization:** 343

2021 Work RVU: 3.50
2021 NF PE RVU: 5.95
2021 Fac PE RVU: 4.45

RUC Recommendation: 3.50 **Referred to CPT** May 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67105 **Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation**

Global: 010 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2015 **2019 est Medicare Utilization:** 3,778

2021 Work RVU: 3.39
2021 NF PE RVU: 4.98
2021 Fac PE RVU: 4.29

RUC Recommendation: 3.84 **Referred to CPT** May 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67107 **Repair of retinal detachment; scleral buckling (such as lamellar scleral dissection, imbrication or encircling procedure), including, when performed, implant, cryotherapy, photocoagulation, and drainage of subretinal fluid**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 623

2021 Work RVU: 16.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.23

RUC Recommendation: 16.00. Reduce 99238 to 0.5 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67108 **Repair of retinal detachment; with vitrectomy, any method, including, when performed, air or gas tamponade, focal endolaser photocoagulation, cryotherapy, drainage of subretinal fluid, scleral buckling, and/or removal of lens by same technique**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 16,523

2021 Work RVU: 17.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.93

RUC Recommendation: 17.13 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67110 **Repair of retinal detachment; by injection of air or other gas (eg, pneumatic retinopexy)**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** Site of Service Anomaly (99238-Only) / 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO

First Identified: September 2007 **2019 est Medicare Utilization:** 2,305

2021 Work RVU: 10.25
2021 NF PE RVU: 14.89
2021 Fac PE RVU: 12.46

RUC Recommendation: 10.25. Remove 99238 **Referred to CPT** October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67112 **Repair of retinal detachment; by scleral buckling or vitrectomy, on patient having previous ipsilateral retinal detachment repair(s) using scleral buckling or vitrectomy techniques**

Global: **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO

First Identified: April 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67113 **Repair of complex retinal detachment (eg, proliferative vitreoretinopathy, stage c-1 or greater, diabetic traction retinal detachment, retinopathy of prematurity, retinal tear of greater than 90 degrees), with vitrectomy and membrane peeling, including, when performed, air, gas, or silicone oil tamponade, cryotherapy, endolaser photocoagulation, drainage of subretinal fluid, scleral buckling, and/or removal of lens**

Global: 090 **Issue:** Retinal Detachment Repair **Screen:** 090-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 12,384

2021 Work RVU: 19.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 17.96

RUC Recommendation: 19.00 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67141 **Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; cryotherapy, diathermy**

Global: 090 **Issue:** Retinal Detachment Prophylaxis **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 08 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** January 2020 **2019 est Medicare Utilization:** 1,395

2021 Work RVU: 6.15
2021 NF PE RVU: 8.63
2021 Fac PE RVU: 7.41

RUC Recommendation: 2.53 **Referred to CPT** May 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67145 **Prophylaxis of retinal detachment (eg, retinal break, lattice degeneration) without drainage; photocoagulation**

Global: 090 **Issue:** Retinal Detachment Prophylaxis **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 08 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2019 **2019 est Medicare Utilization:** 31,865

2021 Work RVU: 6.32
2021 NF PE RVU: 8.51
2021 Fac PE RVU: 7.52

RUC Recommendation: 2.53 **Referred to CPT** May 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67210 **Destruction of localized lesion of retina (eg, macular edema, tumors), 1 or more sessions; photocoagulation**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 56,884

2021 Work RVU: 6.36
2021 NF PE RVU: 8.14
2021 Fac PE RVU: 7.54

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67220 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photocoagulation (eg, laser), 1 or more sessions**

Global: 090 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 13 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,636

2021 Work RVU: 6.36
2021 NF PE RVU: 8.62
2021 Fac PE RVU: 7.54

RUC Recommendation: 6.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67225 **Destruction of localized lesion of choroid (eg, choroidal neovascularization); photodynamic therapy, second eye, at single session (list separately in addition to code for primary eye treatment)**

Global: ZZZ **Issue:** Photodynamic Therapy of the Eye **Screen:** New Technology **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** P **Specialty Developing Recommendation:** AAO **First Identified:** September 2007 **2019 est Medicare Utilization:** 168

2021 Work RVU: 0.47
2021 NF PE RVU: 0.34
2021 Fac PE RVU: 0.29

RUC Recommendation: 0.47 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

67228 **Treatment of extensive or progressive retinopathy (eg, diabetic retinopathy), photocoagulation**

Global: 010 **Issue:** Treatment of Retinal Lesion or Choroid **Screen:** High IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 62,152

2021 Work RVU: 4.39
2021 NF PE RVU: 5.16
2021 Fac PE RVU: 4.04

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67255 **Scleral reinforcement (separate procedure); with graft** **Global:** 090 **Issue:** Aqueous Shunt **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 12 **Specialty Developing Recommendation:** AAO **First Identified:** January 2014 **2019 est Medicare Utilization:** 833

2021 Work RVU: 8.38
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.83

RUC Recommendation: 10.17 **Referred to CPT** October 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

67311 **Strabismus surgery, recession or resection procedure; 1 horizontal muscle** **Global:** 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 4,955

2021 Work RVU: 7.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.90

RUC Recommendation: 5.93 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

67312 **Strabismus surgery, recession or resection procedure; 2 horizontal muscles** **Global:** 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 1,514

2021 Work RVU: 9.66
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.47

RUC Recommendation: 9.50 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67314 **Strabismus surgery, recession or resection procedure; 1 vertical muscle (excluding superior oblique)**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 2,533

2021 Work RVU: 8.79
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.32

RUC Recommendation: 5.93 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67316 **Strabismus surgery, recession or resection procedure; 2 or more vertical muscles (excluding superior oblique)**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 168

2021 Work RVU: 10.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 11.62

RUC Recommendation: 10.31 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67318 **Strabismus surgery, any procedure, superior oblique muscle**

Global: 090 **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** April 2020 **2019 est Medicare Utilization:** 205

2021 Work RVU: 9.12
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.86

RUC Recommendation: 9.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67320 **Transposition procedure (eg, for paretic extraocular muscle), any extraocular muscle (specify) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 362

2021 Work RVU: 5.40
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.31

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67331 **Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 902

2021 Work RVU: 5.13
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.15

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67332 **Strabismus surgery on patient with scarring of extraocular muscles (eg, prior ocular injury, strabismus or retinal detachment surgery) or restrictive myopathy (eg, dysthyroid ophthalmopathy) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,753

2021 Work RVU: 5.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.41

RUC Recommendation: 3.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67334 **Strabismus surgery by posterior fixation suture technique, with or without muscle recession (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 128

2021 Work RVU: 5.05
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.11

RUC Recommendation: 2.06 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67335 **Placement of adjustable suture(s) during strabismus surgery, including postoperative adjustment(s) of suture(s) (list separately in addition to code for specific strabismus surgery)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 1,681

2021 Work RVU: 2.49
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.52

RUC Recommendation: 3.23 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

67340 **Strabismus surgery involving exploration and/or repair of detached extraocular muscle(s) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Strabismus Surgery **Screen:** ZZZ Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 18 **Specialty Developing Recommendation:** AAO, AAP **First Identified:** October 2019 **2019 est Medicare Utilization:** 88

2021 Work RVU: 6.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.71

RUC Recommendation: 5.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67500 **Retrobulbar injection; medication (separate procedure, does not include supply of medication)**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2017 **2019 est Medicare Utilization:** 7,903

2021 Work RVU: 1.18
2021 NF PE RVU: 0.91
2021 Fac PE RVU: 0.52

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67505 **Retrobulbar injection; alcohol**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2017 **2019 est Medicare Utilization:** 140

2021 Work RVU: 1.18
2021 NF PE RVU: 1.26
2021 Fac PE RVU: 0.82

RUC Recommendation: 1.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67515 **Injection of medication or other substance into tenon's capsule**

Global: 000 **Issue:** Injection – Eye **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 11 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** July 2016 **2019 est Medicare Utilization:** 24,360

2021 Work RVU: 0.75
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.56

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67820 **Correction of trichiasis; epilation, by forceps only**

Global: 000 **Issue:** Correction of Trichiasis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 29 **Specialty Developing Recommendation:** AOA, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 222,157

2021 Work RVU: 0.32
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.32 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

67914 **Repair of ectropion; suture**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 1,601

2021 Work RVU: 3.75
2021 NF PE RVU: 10.51
2021 Fac PE RVU: 5.40

RUC Recommendation: 3.75

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

67915 **Repair of ectropion; thermocauterization**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 332

2021 Work RVU: 2.03
2021 NF PE RVU: 7.26
2021 Fac PE RVU: 3.54

RUC Recommendation: 2.03

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67916 **Repair of ectropion; excision tarsal wedge**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 1,895

2021 Work RVU: 5.48
2021 NF PE RVU: 12.24
2021 Fac PE RVU: 6.46

RUC Recommendation: 5.48

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

67917 **Repair of ectropion; extensive (eg, tarsal strip operations)**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 24,678

2021 Work RVU: 5.93
2021 NF PE RVU: 12.07
2021 Fac PE RVU: 6.75

RUC Recommendation: 5.93

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

67921 **Repair of entropion; suture**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 3,614

2021 Work RVU: 3.47
2021 NF PE RVU: 10.56
2021 Fac PE RVU: 5.25

RUC Recommendation: 3.47

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

67922 **Repair of entropion; thermocauterization**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO

First Identified: October 2012 **2019 est Medicare Utilization:** 100

2021 Work RVU: 2.03
2021 NF PE RVU: 6.95
2021 Fac PE RVU: 3.52

RUC Recommendation: 2.03

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

67923 **Repair of entropion; excision tarsal wedge**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,300

2021 Work RVU: 5.48
2021 NF PE RVU: 12.25
2021 Fac PE RVU: 6.48

RUC Recommendation: 5.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

67924 **Repair of entropion; extensive (eg, tarsal strip or capsulopalpebral fascia repairs operation)**

Global: 090 **Issue:** Repair of Eyelid **Screen:** Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 24 **Specialty Developing Recommendation:** AAO **First Identified:** October 2012 **2019 est Medicare Utilization:** 11,149

2021 Work RVU: 5.93
2021 NF PE RVU: 12.90
2021 Fac PE RVU: 6.76

RUC Recommendation: 5.93 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

68040 **Expression of conjunctival follicles (eg, for trachoma)**

Global: 000 **Issue:** Treatment of Eyelid Lesions **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** AAO **First Identified:** February 2008 **2019 est Medicare Utilization:** 6,702

2021 Work RVU: 0.85
2021 NF PE RVU: 0.91
2021 Fac PE RVU: 0.49

RUC Recommendation: Revised parenthetical **Referred to CPT** February 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

68200 **Subconjunctival injection**

Global: 000 **Issue:** Subconjunctival Injection **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,059

2021 Work RVU: 0.49
2021 NF PE RVU: 0.68
2021 Fac PE RVU: 0.46

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

68801 **Dilation of lacrimal punctum, with or without irrigation**

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** January 2014 **2019 est Medicare Utilization:** 27,980

2021 Work RVU: 0.82
2021 NF PE RVU: 1.91
2021 Fac PE RVU: 1.39

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

68810 **Probing of nasolacrimal duct, with or without irrigation;**

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** Site of Service Anomaly / 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** September 2007 **2019 est Medicare Utilization:** 28,019

2021 Work RVU: 1.54
2021 NF PE RVU: 3.07
2021 Fac PE RVU: 2.02

RUC Recommendation: 1.54 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

68811 **Probing of nasolacrimal duct, with or without irrigation; requiring general anesthesia**

Global: 010 **Issue:** **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry)

First Identified: September 2014 **2019 est Medicare Utilization:** 451

2021 Work RVU: 1.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.01

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

68815 **Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent**

Global: 010 **Issue:** Dilation and Probing of Lacrimal and Nasolacrimal Duct **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry)

First Identified: January 2014 **2019 est Medicare Utilization:** 8,129

2021 Work RVU: 2.70
2021 NF PE RVU: 8.61
2021 Fac PE RVU: 3.49

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

68816 **Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation**

Global: 010 **Issue:** **Screen:** 010-Day Global Post-Operative Visits **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (optometry)

First Identified: September 2014 **2019 est Medicare Utilization:** 248

2021 Work RVU: 2.10
2021 NF PE RVU: 23.29
2021 Fac PE RVU: 2.26

RUC Recommendation: 2.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

69100 **Biopsy external ear**

Global: 000 **Issue:** Biopsy of Ear **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 28 **Specialty Developing Recommendation:** AAD

First Identified: October 2008 **2019 est Medicare Utilization:** 164,973

2021 Work RVU: 0.81
2021 NF PE RVU: 2.01
2021 Fac PE RVU: 0.46

RUC Recommendation: 0.81 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69200 **Removal foreign body from external auditory canal; without general anesthesia** **Global:** 000 **Issue:** Removal of Foreign Body **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 29 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2011 **2019 est Medicare Utilization:** 59,479

2021 Work RVU: 0.77
2021 NF PE RVU: 1.51
2021 Fac PE RVU: 0.49

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

69210 **Removal impacted cerumen requiring instrumentation, unilateral** **Global:** 000 **Issue:** Removal of Cerumen **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 29 **Specialty Developing Recommendation:** AAFP, AAO-HNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,589,620

2021 Work RVU: 0.61
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.27

RUC Recommendation: 0.58. **Referred to CPT** October 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

69400 **Eustachian tube inflation, transnasal; with catheterization** **Global:** **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

69401 **Eustachian tube inflation, transnasal; without catheterization** **Global:** **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

69405 **Eustachian tube catheterization, transtympanic**

Global: **Issue:** Eustachian Tube Procedures **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** AAO-HNS

First Identified: October 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

69433 **Tympanostomy (requiring insertion of ventilating tube), local or topical anesthesia**

Global: 010 **Issue:** Tympanostomy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 30 **Specialty Developing Recommendation:** AAO-HNS

First Identified: April 2011 **2019 est Medicare Utilization:** 48,248

2021 Work RVU: 1.57
2021 NF PE RVU: 4.15
2021 Fac PE RVU: 2.03

RUC Recommendation: 1.57

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

69801 **Labyrinthotomy, with perfusion of vestibuloactive drug(s), transcanal**

Global: 000 **Issue:** Labyrinthotomy **Screen:** CMS Fastest Growing / Site of Service Anomaly (99238-Only) / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** AAO-HNS

First Identified: September 2007 **2019 est Medicare Utilization:** 24,321

2021 Work RVU: 2.06
2021 NF PE RVU: 4.22
2021 Fac PE RVU: 1.26

RUC Recommendation: Review action plan at RAW Oct 2015. 2.06

Referred to CPT Feb 2010 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** May 2011

Status Report: CMS Requests and Relativity Assessment Issues

69802 **Labyrinthotomy, with perfusion of vestibuloactive drug(s); with mastoidectomy** **Global:** **Issue:** Labryinthotomy **Screen:** CMS Fastest Growing / Site of Service Anomaly (99238-Only) **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 16 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** Feburary 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

69930 **Cochlear device implantation, with or without mastoidectomy** **Global:** 090 **Issue:** Cochlear Device Implantation **Screen:** Site of Service Anomaly **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** M **Specialty Developing Recommendation:** AAO-HNS **First Identified:** September 2007 **2019 est Medicare Utilization:** 4,267

2021 Work RVU: 17.73
2021 NF PE RVU: NA
2021 Fac PE RVU: 15.81

RUC Recommendation: 17.60 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70030 **Radiologic examination, eye, for detection of foreign body** **Global:** XXX **Issue:** X-Ray of Eye **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 28 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 23,756

2021 Work RVU: 0.18
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70100 **Radiologic examination, mandible; partial, less than 4 views** **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 20,165

2021 Work RVU: 0.18
2021 NF PE RVU: 0.92
2021 Fac PE RVU: NA

RUC Recommendation: RUC to submit letter to CMS specifying the innapropriate reporting of this service with the hand-held device in Texas.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70210 **Radiologic examination, sinuses, paranasal, less than 3 views** **Global:** XXX **Issue:** X-Ray Exam - Sinuses **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 24 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 31,748

2021 Work RVU: 0.17
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.20

Referred to CPT

Result: Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

70220 **Radiologic examination, sinuses, paranasal, complete, minimum of 3 views** **Global:** XXX **Issue:** X-Ray Exam - Sinuses **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 24 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 59,212

2021 Work RVU: 0.22
2021 NF PE RVU: 0.86
2021 Fac PE RVU: NA

RUC Recommendation: 0.22

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70250 **Radiologic examination, skull; less than 4 views**

Global: XXX **Issue:** X-Ray Exam – Skull **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 25 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 45,019

2021 Work RVU: 0.18
2021 NF PE RVU: 0.84
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70260 **Radiologic examination, skull; complete, minimum of 4 views**

Global: XXX **Issue:** X-Ray Exam – Skull **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 25 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 9,622

2021 Work RVU: 0.28
2021 NF PE RVU: 1.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.29 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70310 **Radiologic examination, teeth; partial examination, less than full mouth**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,217

2021 Work RVU: 0.16
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: RUC to submit letter to CMS specifying the innapropriate reporting of this service with the hand-held device in Texas. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70360 **Radiologic examination; neck, soft tissue** **Global:** XXX **Issue:** X-Ray Exam – Neck **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 26 **Specialty Developing Recommendation:** AAFP, ACP, ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 64,675

2021 Work RVU: 0.18
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

70371 **Complex dynamic pharyngeal and speech evaluation by cine or video recording** **Global:** XXX **Issue:** Laryngography **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACR, AAFP **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,976

2021 Work RVU: 0.84
2021 NF PE RVU: 2.31
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published, addressed issues identified. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

70373 **Laryngography, contrast, radiological supervision and interpretation** **Global:** **Issue:** Laryngography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** **Specialty Developing Recommendation:** ACR, AAFP **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: CPT Assistant article published. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

Status Report: CMS Requests and Relativity Assessment Issues

70450 **Computed tomography, head or brain; without contrast material**

Global: XXX **Issue:** CT Head/Brain **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,711,912

2021 Work RVU: 0.85
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70460 **Computed tomography, head or brain; with contrast material(s)**

Global: XXX **Issue:** CT Head/Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 28,050

2021 Work RVU: 1.13
2021 NF PE RVU: 3.49
2021 Fac PE RVU: NA

RUC Recommendation: 1.13 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70470 **Computed tomography, head or brain; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Head/Brain **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:** 92,135

2021 Work RVU: 1.27
2021 NF PE RVU: 4.17
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70480 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material**

Global: XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 54,791

2021 Work RVU: 1.28
2021 NF PE RVU: 3.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.28 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70481 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material(s)**

Global: XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 10,929

2021 Work RVU: 1.13
2021 NF PE RVU: 4.56
2021 Fac PE RVU: NA

RUC Recommendation: 1.13 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70482 **Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT – Orbit/Ear/Fossa **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 16 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2017 **2019 est Medicare Utilization:** 4,917

2021 Work RVU: 1.27
2021 NF PE RVU: 5.42
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70486 **Computed tomography, maxillofacial area; without contrast material**

Global: XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 532,110

2021 Work RVU: 0.85
2021 NF PE RVU: 3.13
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70487 **Computed tomography, maxillofacial area; with contrast material(s)**

Global: XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 30,559

2021 Work RVU: 1.13
2021 NF PE RVU: 3.62
2021 Fac PE RVU: NA

RUC Recommendation: 1.17 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70488 **Computed tomography, maxillofacial area; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT – Maxillofacial **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 41 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2014 **2019 est Medicare Utilization:** 3,505

2021 Work RVU: 1.27
2021 NF PE RVU: 4.56
2021 Fac PE RVU: NA

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70490 **Computed tomography, soft tissue neck; without contrast material**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 68,230

2021 Work RVU: 1.28
2021 NF PE RVU: 3.38
2021 Fac PE RVU: NA

RUC Recommendation: 1.28 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70491 **Computed tomography, soft tissue neck; with contrast material(s)**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 279,888

2021 Work RVU: 1.38
2021 NF PE RVU: 4.41
2021 Fac PE RVU: NA

RUC Recommendation: 1.38 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70492 **Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Soft Tissue Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 25,867

2021 Work RVU: 1.62
2021 NF PE RVU: 5.37
2021 Fac PE RVU: NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

70496 **Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography – Head & Neck **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth2 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2008 **2019 est Medicare Utilization:** 525,192

2021 Work RVU: 1.75
2021 NF PE RVU: 6.80
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70498 **Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography – Head & Neck **Screen:** High Volume Growth1 / CMS Fastest Growing / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2008 **2019 est Medicare Utilization:** 546,880

2021 Work RVU: 1.75
2021 NF PE RVU: 6.79
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70540 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 10,325

2021 Work RVU: 1.35
2021 NF PE RVU: 6.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70542 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; with contrast material(s)**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 993

2021 Work RVU: 1.62
2021 NF PE RVU: 7.14
2021 Fac PE RVU: NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70543 **Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI Face and Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 39 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 61,843

2021 Work RVU: 2.15
2021 NF PE RVU: 8.88
2021 Fac PE RVU: NA

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70544 **Magnetic resonance angiography, head; without contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 247,119

2021 Work RVU: 1.20
2021 NF PE RVU: 5.71
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70545 **Magnetic resonance angiography, head; with contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 3,638

2021 Work RVU: 1.20
2021 NF PE RVU: 6.08
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70546 **Magnetic resonance angiography, head; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 18,220

2021 Work RVU: 1.48
2021 NF PE RVU: 9.09
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

70547 **Magnetic resonance angiography, neck; without contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 78,876

2021 Work RVU: 1.20
2021 NF PE RVU: 5.74
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70548 **Magnetic resonance angiography, neck; with contrast material(s)**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 17,524

2021 Work RVU: 1.50
2021 NF PE RVU: 6.32
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70549 **Magnetic resonance angiography, neck; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** Magnetic Resonance Angiography (MR) Head/Neck **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2015 **2019 est Medicare Utilization:** 58,959

2021 Work RVU: 1.80
2021 NF PE RVU: 9.27
2021 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70551 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,166,152

2021 Work RVU: 1.48
2021 NF PE RVU: 4.76
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

70552 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); with contrast material(s)**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,951

2021 Work RVU: 1.78
2021 NF PE RVU: 6.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

70553 **Magnetic resonance (eg, proton) imaging, brain (including brain stem); without contrast material, followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI-Brain **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 26 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,005,264

2021 Work RVU: 2.29
2021 NF PE RVU: 7.97
2021 Fac PE RVU: NA

RUC Recommendation: 2.36 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71010 **Radiologic examination, chest; single view, frontal**

Global: **Issue:** Chest X-Rays **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71015 **Radiologic examination, chest; stereo, frontal**

Global: **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71020 **Radiologic examination, chest, 2 views, frontal and lateral;** **Global:** **Issue:** Chest X-Rays **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71021 **Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71022 **Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections** **Global:** **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71023 **Radiologic examination, chest, 2 views, frontal and lateral; with fluoroscopy**

Global: **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71030 **Radiologic examination, chest, complete, minimum of 4 views;**

Global: **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71034 **Radiologic examination, chest, complete, minimum of 4 views; with fluoroscopy**

Global: **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71035 **Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)**

Global: **Issue:** Chest X-Rays **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71045 **Radiologic examination, chest; single view**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 15,582,853

2021 Work RVU: 0.18
2021 NF PE RVU: 0.55
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

71046 **Radiologic examination, chest; 2 views**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 10,465,557

2021 Work RVU: 0.22
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

71047 **Radiologic examination, chest; 3 views**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 15,324

2021 Work RVU: 0.27
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

71048 **Radiologic examination, chest; 4 or more views**

Global: XXX **Issue:** Chest X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: February 2016 **2019 est Medicare Utilization:** 10,897

2021 Work RVU: 0.31
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71090 **Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation**

Global: **Issue:** Insertion/Removal of Pacemeaker or Pacing Cardioverter-Defibrillator **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

71100 **Radiologic examination, ribs, unilateral; 2 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 174,554

2021 Work RVU: 0.22
2021 NF PE RVU: 0.83
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71101 **Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 301,474

2021 Work RVU: 0.27
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71110 **Radiologic examination, ribs, bilateral; 3 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR

First Identified: October 2015 **2019 est Medicare Utilization:** 24,795

2021 Work RVU: 0.29
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.29 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71111 **Radiologic examination, ribs, bilateral; including posteroanterior chest, minimum of 4 views**

Global: XXX **Issue:** X-Ray of Ribs **Screen:** CMS-Other - Utilization over 250,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 30 **Specialty Developing Recommendation:** ACR

First Identified: October 2015 **2019 est Medicare Utilization:** 30,595

2021 Work RVU: 0.32
2021 NF PE RVU: 1.19
2021 Fac PE RVU: NA

RUC Recommendation: 0.32 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

71250 **Computed tomography, thorax, diagnostic; without contrast material**

Global: XXX **Issue:** Screening CT of Thorax **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** ACR

First Identified: October 2008 **2019 est Medicare Utilization:** 2,320,224

2021 Work RVU: 1.08
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71260 **Computed tomography, thorax, diagnostic; with contrast material(s)** **Global:** XXX **Issue:** Screening CT of Thorax **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,835,534

2021 Work RVU: 1.16
2021 NF PE RVU: 4.07
2021 Fac PE RVU: NA

RUC Recommendation: 1.38 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

71270 **Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** Screening CT of Thorax **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 70,977

2021 Work RVU: 1.25
2021 NF PE RVU: 4.96
2021 Fac PE RVU: NA

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

71271 **Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)** **Global:** XXX **Issue:** Screening CT of Thorax **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:** **First Identified:** May 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.08
2021 NF PE RVU: 3.18
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

71275 **Computed tomographic angiography, chest (noncoronary), with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography-Chest **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 27 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,282,747

2021 Work RVU: 1.82
2021 NF PE RVU: 6.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.82 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2009

72020 **Radiologic examination, spine, single view, specify level**

Global: XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2016 **2019 est Medicare Utilization:** 145,820

2021 Work RVU: 0.16
2021 NF PE RVU: 0.54
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72040 **Radiologic examination, spine, cervical; 2 or 3 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 641,468

2021 Work RVU: 0.22
2021 NF PE RVU: 0.91
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72050 **Radiologic examination, spine, cervical; 4 or 5 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 378,821

2021 Work RVU: 0.27
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72052 **Radiologic examination, spine, cervical; 6 or more views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2010 **2019 est Medicare Utilization:** 80,862

2021 Work RVU: 0.30
2021 NF PE RVU: 1.49
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72070 **Radiologic examination, spine; thoracic, 2 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2013 **2019 est Medicare Utilization:** 300,255

2021 Work RVU: 0.20
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72072 **Radiologic examination, spine; thoracic, 3 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** April 2016 **2019 est Medicare Utilization:** 184,802

2021 Work RVU: 0.23
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.23 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72074 **Radiologic examination, spine; thoracic, minimum of 4 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2016 **2019 est Medicare Utilization:** 12,934

2021 Work RVU: 0.25
2021 NF PE RVU: 1.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72080 **Radiologic examination, spine; thoracolumbar junction, minimum of 2 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2016 **2019 est Medicare Utilization:** 46,745

2021 Work RVU: 0.21
2021 NF PE RVU: 0.78
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72100 **Radiologic examination, spine, lumbosacral; 2 or 3 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / Low Value-High Volume / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,818,987

2021 Work RVU: 0.22
2021 NF PE RVU: 0.92
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72110 **Radiologic examination, spine, lumbosacral; minimum of 4 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:** 821,121

2021 Work RVU: 0.26
2021 NF PE RVU: 1.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

72114 **Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views**

Global: XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 96,261

2021 Work RVU: 0.30
2021 NF PE RVU: 1.49
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72120 **Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views** **Global:** XXX **Issue:** X-Ray Spine **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 27 **Specialty Developing Recommendation:** AAOS, ACR, ASNR **First Identified:** February 2010 **2019 est Medicare Utilization:** 52,798

2021 Work RVU: 0.22
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72125 **Computed tomography, cervical spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,308,607

2021 Work RVU: 1.00
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.07 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72126 **Computed tomography, cervical spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 20,553

2021 Work RVU: 1.22
2021 NF PE RVU: 4.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72127 **Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,798

2021 Work RVU: 1.27
2021 NF PE RVU: 4.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72128 **Computed tomography, thoracic spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2008 **2019 est Medicare Utilization:** 199,533

2021 Work RVU: 1.00
2021 NF PE RVU: 3.03
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72129 **Computed tomography, thoracic spine; with contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 26,437

2021 Work RVU: 1.22
2021 NF PE RVU: 4.09
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72130 **Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,318

2021 Work RVU: 1.27
2021 NF PE RVU: 4.97
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72131 **Computed tomography, lumbar spine; without contrast material** **Global:** XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 519,043

2021 Work RVU: 1.00
2021 NF PE RVU: 3.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72132 **Computed tomography, lumbar spine; with contrast material**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,654

2021 Work RVU: 1.22
2021 NF PE RVU: 4.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72133 **Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Spine **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** February 2009 **2019 est Medicare Utilization:** 4,078

2021 Work RVU: 1.27
2021 NF PE RVU: 4.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.27 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72141 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** September 2011 **2019 est Medicare Utilization:** 600,156

2021 Work RVU: 1.48
2021 NF PE RVU: 4.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72142 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, cervical; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,391

2021 Work RVU: 1.78
2021 NF PE RVU: 7.12
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72146 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 223,500

2021 Work RVU: 1.48
2021 NF PE RVU: 4.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

72147 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, thoracic; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 3,124

2021 Work RVU: 1.78
2021 NF PE RVU: 7.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72148 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; without contrast material**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, AUR, ACR, NASS, ASNR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,346,832

2021 Work RVU: 1.48
2021 NF PE RVU: 4.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72149 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, lumbar; with contrast material(s)**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 5,622

2021 Work RVU: 1.78
2021 NF PE RVU: 6.98
2021 Fac PE RVU: NA

RUC Recommendation: 1.78 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72156 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; cervical**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 120,879

2021 Work RVU: 2.29
2021 NF PE RVU: 8.07
2021 Fac PE RVU: NA

RUC Recommendation: 2.29 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72157 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; thoracic**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 98,889

2021 Work RVU: 2.29
2021 NF PE RVU: 8.09
2021 Fac PE RVU: NA

RUC Recommendation: 2.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

72158 **Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar**

Global: XXX **Issue:** MRI Neck and Lumbar Spine **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 25 **Specialty Developing Recommendation:**

First Identified: April 2013

2019 est Medicare Utilization: 244,364

2021 Work RVU: 2.29
2021 NF PE RVU: 8.05
2021 Fac PE RVU: NA

RUC Recommendation: 2.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

72170 **Radiologic examination, pelvis; 1 or 2 views**

Global: XXX **Issue:** X-Ray Exam – Pelvis **Screen:** Low Value-High Volume / Codes Reported Together 75% or More-Part2 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 28 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010

2019 est Medicare Utilization: 792,294

2021 Work RVU: 0.17
2021 NF PE RVU: 0.62
2021 Fac PE RVU: NA

RUC Recommendation: 0.17

Referred to CPT October 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

72190 **Radiologic examination, pelvis; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Exam – Pelvis **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 28 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 56,338

2021 Work RVU: 0.25
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

72191 **Computed tomographic angiography, pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth1 / CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,441

2021 Work RVU: 1.81
2021 NF PE RVU: 7.69
2021 Fac PE RVU: NA

RUC Recommendation: 1.81 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72192 **Computed tomography, pelvis; without contrast material**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 183,953

2021 Work RVU: 1.09
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.09 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72193 **Computed tomography, pelvis; with contrast material(s)**

Global: XXX **Issue:** CT Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 37,206

2021 Work RVU: 1.16
2021 NF PE RVU: 6.05
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72194 **Computed tomography, pelvis; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Abdomen and Pelvis **Screen:** Codes Reported Together 95% or More / CMS Fastest Growing / CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 44 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,552

2021 Work RVU: 1.22
2021 NF PE RVU: 6.81
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72195 **Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)**

Global: XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 85,947

2021 Work RVU: 1.46
2021 NF PE RVU: 6.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72196 **Magnetic resonance (eg, proton) imaging, pelvis; with contrast material(s)** **Global:** XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 2,606

2021 Work RVU: 1.73
2021 NF PE RVU: 7.04
2021 Fac PE RVU: NA

RUC Recommendation: 1.73 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

72197 **Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s), followed by contrast material(s) and further sequences** **Global:** XXX **Issue:** MRI Pelvis **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 214,192

2021 Work RVU: 2.20
2021 NF PE RVU: 8.83
2021 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

72200 **Radiologic examination, sacroiliac joints; less than 3 views** **Global:** XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 29 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 14,605

2021 Work RVU: 0.17
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

72202 **Radiologic examination, sacroiliac joints; 3 or more views** **Global:** XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 29 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 39,418

2021 Work RVU: 0.23
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

72220 **Radiologic examination, sacrum and coccyx, minimum of 2 views**

Global: XXX **Issue:** X-Ray Sacrum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 29 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: April 2016

2019 est Medicare Utilization: 116,528

2021 Work RVU: 0.17
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.20

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

72240 **Myelography, cervical, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: October 2012

2019 est Medicare Utilization: 647

2021 Work RVU: 0.91
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.91

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

72255 **Myelography, thoracic, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR

First Identified: October 2013

2019 est Medicare Utilization: 125

2021 Work RVU: 0.91
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.91

Referred to CPT October 2013
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

72265 **Myelography, lumbosacral, radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,681

2021 Work RVU: 0.83
2021 NF PE RVU: 2.29
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72270 **Myelography, 2 or more regions (eg, lumbar/thoracic, cervical/thoracic, lumbar/cervical, lumbar/thoracic/cervical), radiological supervision and interpretation**

Global: XXX **Issue:** Myelography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,087

2021 Work RVU: 1.33
2021 NF PE RVU: 2.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.33 **Referred to CPT** October 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

72275 **Epidurography, radiological supervision and interpretation**

Global: XXX **Issue:** Epidurography **Screen:** Different Performing Specialty from Survey3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, NASS **First Identified:** October 2009 **2019 est Medicare Utilization:** 66,516

2021 Work RVU: 0.76
2021 NF PE RVU: 3.29
2021 Fac PE RVU: NA

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2009 and Q&A - May 2010

Status Report: CMS Requests and Relativity Assessment Issues

72291 **Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under fluoroscopic guidance**

Global: **Issue:** Percutaneous Vertebroplasty with Radiological S&I **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

72292 **Radiological supervision and interpretation, percutaneous vertebroplasty, vertebral augmentation, or sacral augmentation (sacroplasty), including cavity creation, per vertebral body or sacrum; under CT guidance**

Global: **Issue:** Percutaneous Vertebroplasty with Radiological S&I **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 06 **Specialty Developing Recommendation:**

First Identified: October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

73000 **Radiologic examination; clavicle, complete**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS

First Identified: October 2017 **2019 est Medicare Utilization:** 100,682

2021 Work RVU: 0.16
2021 NF PE RVU: 0.76
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73010 **Radiologic examination; scapula, complete**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2017 **2019 est Medicare Utilization:** 51,052

2021 Work RVU: 0.17
2021 NF PE RVU: 0.50
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73020 **Radiologic examination, shoulder; 1 view**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2017 **2019 est Medicare Utilization:** 119,144

2021 Work RVU: 0.15
2021 NF PE RVU: 0.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73030 **Radiologic examination, shoulder; complete, minimum of 2 views**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** Low Value-High Volume / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,765,924

2021 Work RVU: 0.18
2021 NF PE RVU: 0.80
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73050 **Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction**

Global: XXX **Issue:** X-Ray – Clavicle/Shoulder **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 17 **Specialty Developing Recommendation:** ACR, AAOS **First Identified:** October 2017 **2019 est Medicare Utilization:** 8,123

2021 Work RVU: 0.18
2021 NF PE RVU: 0.63
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73060 **Radiologic examination; humerus, minimum of 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 341,436

2021 Work RVU: 0.16
2021 NF PE RVU: 0.76
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73070 **Radiologic examination, elbow; 2 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** April 2016 **2019 est Medicare Utilization:** 219,794

2021 Work RVU: 0.16
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73080 **Radiologic examination, elbow; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** Harvard Valued - Utilization over 100,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** October 2009 **2019 est Medicare Utilization:** 404,093

2021 Work RVU: 0.17
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73090 **Radiologic examination; forearm, 2 views**

Global: XXX **Issue:** X-Ray Elbow/Forearm **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 30 **Specialty Developing Recommendation:** AAOS, ACR, ASSH **First Identified:** April 2016 **2019 est Medicare Utilization:** 230,897

2021 Work RVU: 0.16
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73100 **Radiologic examination, wrist; 2 views**

Global: XXX **Issue:** X-Ray Wrist **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 32 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 274,134

2021 Work RVU: 0.16
2021 NF PE RVU: 0.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73110 **Radiologic examination, wrist; complete, minimum of 3 views**

Global: XXX **Issue:** X-Ray Wrist **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 32 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,064,258

2021 Work RVU: 0.17
2021 NF PE RVU: 0.99
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73120 **Radiologic examination, hand; 2 views**

Global: XXX **Issue:** X-Ray of Hand/Fingers **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 33 **Specialty Developing Recommendation:** ACR

First Identified: July 2015 **2019 est Medicare Utilization:** 278,753

2021 Work RVU: 0.16
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73130 **Radiologic examination, hand; minimum of 3 views**

Global: XXX **Issue:** X-Ray of Hand/Fingers **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 33 **Specialty Developing Recommendation:** ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,282,863

2021 Work RVU: 0.17
2021 NF PE RVU: 0.87
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73140 **Radiologic examination, finger(s), minimum of 2 views**

Global: XXX **Issue:** X-Ray of Hand/Fingers **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 33 **Specialty Developing Recommendation:** ACR

First Identified: July 2015

2019 est Medicare Utilization: 388,288

2021 Work RVU: 0.13
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.13

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

73200 **Computed tomography, upper extremity; without contrast material**

Global: XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 23 **Specialty Developing Recommendation:** ACR

First Identified: October 2008

2019 est Medicare Utilization: 126,320

2021 Work RVU: 1.00
2021 NF PE RVU: 4.14
2021 Fac PE RVU: NA

RUC Recommendation: 1.09

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

73201 **Computed tomography, upper extremity; with contrast material(s)**

Global: XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACR

First Identified: February 2009

2019 est Medicare Utilization: 21,360

2021 Work RVU: 1.16
2021 NF PE RVU: 5.25
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

73202 **Computed tomography, upper extremity; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Upper Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 40 **Specialty Developing Recommendation:** ACR

First Identified: February 2009

2019 est Medicare Utilization: 1,982

2021 Work RVU: 1.22
2021 NF PE RVU: 6.80
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

Status Report: CMS Requests and Relativity Assessment Issues

73206 **Computed tomographic angiography, upper extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** May 2013 **2019 est Medicare Utilization:** 6,543

2021 Work RVU: 1.81
2021 NF PE RVU: 7.60
2021 Fac PE RVU: NA

RUC Recommendation: Survey with all CTA codes for October 2013.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

73218 **Magnetic resonance (eg, proton) imaging, upper extremity, other than joint; without contrast material(s)**

Global: XXX **Issue:** MRI **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 33,624

2021 Work RVU: 1.35
2021 NF PE RVU: 8.72
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant published.

Referred to CPT
Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2011

Result: Maintain

73221 **Magnetic resonance (eg, proton) imaging, any joint of upper extremity; without contrast material(s)**

Global: XXX **Issue:** MRI **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 475,051

2021 Work RVU: 1.35
2021 NF PE RVU: 5.13
2021 Fac PE RVU: NA

RUC Recommendation: 1.35

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

73500 **Radiologic examination, hip, unilateral; 1 view**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 500,000 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

73501 **Radiologic examination, hip, unilateral, with pelvis when performed; 1 view**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 285,022

2021 Work RVU: 0.18
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

73502 **Radiologic examination, hip, unilateral, with pelvis when performed; 2-3 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 2,694,536

2021 Work RVU: 0.22
2021 NF PE RVU: 1.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73503 **Radiologic examination, hip, unilateral, with pelvis when performed; minimum of 4 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 46,804

2021 Work RVU: 0.27
2021 NF PE RVU: 1.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73510 **Radiologic examination, hip, unilateral; complete, minimum of 2 views**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

73520 **Radiologic examination, hips, bilateral, minimum of 2 views of each hip, including anteroposterior view of pelvis**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73521 **Radiologic examination, hips, bilateral, with pelvis when performed; 2 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 158,149

2021 Work RVU: 0.22
2021 NF PE RVU: 0.96
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73522 **Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 188,143

2021 Work RVU: 0.29
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: 0.29 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73523 **Radiologic examination, hips, bilateral, with pelvis when performed; minimum of 5 views** **Global:** XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:** 107,476

2021 Work RVU: 0.31
2021 NF PE RVU: 1.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73540 **Radiologic examination, pelvis and hips, infant or child, minimum of 2 views**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

73542 **Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation**

Global: **Issue:** Sacroiliac Joint Arthrography **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ASA, AAPM, AAMPR, NASS, ACR, AUR, ISIS, ASNR **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Deleted from CPT

73550 **Radiologic examination, femur, 2 views**

Global: **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73551 **Radiologic examination, femur; 1 view**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2014 **2019 est Medicare Utilization:** 37,871

2021 Work RVU: 0.16
2021 NF PE RVU: 0.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.16

Referred to CPT October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73552 **Radiologic examination, femur; minimum 2 views**

Global: XXX **Issue:** Radiologic Exam-Hip and Pelvis **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2014 **2019 est Medicare Utilization:** 548,327

2021 Work RVU: 0.18
2021 NF PE RVU: 0.83
2021 Fac PE RVU: NA

RUC Recommendation: 0.18

Referred to CPT October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73560 **Radiologic examination, knee; 1 or 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 1,784,814

2021 Work RVU: 0.16
2021 NF PE RVU: 0.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.16

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73562 **Radiologic examination, knee; 3 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR

First Identified: October 2010 **2019 est Medicare Utilization:** 2,516,006

2021 Work RVU: 0.18
2021 NF PE RVU: 0.98
2021 Fac PE RVU: NA

RUC Recommendation: 0.18

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73564 **Radiologic examination, knee; complete, 4 or more views** **Global:** XXX **Issue:** X-Ray Exams **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,648,754

2021 Work RVU: 0.22
2021 NF PE RVU: 1.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73565 **Radiologic examination, knee; both knees, standing, anteroposterior** **Global:** XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 207,121

2021 Work RVU: 0.16
2021 NF PE RVU: 1.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73580 **Radiologic examination, knee, arthrography, radiological supervision and interpretation** **Global:** XXX **Issue:** Contrast X-Ray of Knee Joint **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 16 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 30,453

2021 Work RVU: 0.54
2021 NF PE RVU: 3.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Jun 2012

Status Report: CMS Requests and Relativity Assessment Issues

73590 **Radiologic examination; tibia and fibula, 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 500,593

2021 Work RVU: 0.16
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

73600 **Radiologic examination, ankle; 2 views**

Global: XXX **Issue:** X-Ray Exams **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 17 **Specialty Developing Recommendation:** AAOS, ACR, APMA **First Identified:** April 2013 **2019 est Medicare Utilization:** 240,693

2021 Work RVU: 0.16
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73610 **Radiologic examination, ankle; complete, minimum of 3 views**

Global: XXX **Issue:** Radiologic Examination **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,281,503

2021 Work RVU: 0.17
2021 NF PE RVU: 0.88
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73620 **Radiologic examination, foot; 2 views**

Global: XXX **Issue:** X-Ray Exam of Foot **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 27 **Specialty Developing Recommendation:** ACR, AAOS, APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 574,129

2021 Work RVU: 0.16
2021 NF PE RVU: 0.65
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73630 **Radiologic examination, foot; complete, minimum of 3 views**

Global: XXX **Issue:** Radiologic Examination **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 24 **Specialty Developing Recommendation:** ACR, AAOS, APMA, AOFAS **First Identified:** October 2008 **2019 est Medicare Utilization:** 2,820,181

2021 Work RVU: 0.17
2021 NF PE RVU: 0.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73650 **Radiologic examination; calcaneus, minimum of 2 views**

Global: XXX **Issue:** X-Ray Heel **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 31 **Specialty Developing Recommendation:** AAOS, ACR, APMA, AOFAS **First Identified:** April 2016 **2019 est Medicare Utilization:** 81,836

2021 Work RVU: 0.16
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73660 **Radiologic examination; toe(s), minimum of 2 views**

Global: XXX **Issue:** X-Ray Toe **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 32 **Specialty Developing Recommendation:** AAOS, ACR, APMA, AOFAS **First Identified:** April 2016 **2019 est Medicare Utilization:** 120,091

2021 Work RVU: 0.13
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: 0.13 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73700 **Computed tomography, lower extremity; without contrast material**

Global: XXX **Issue:** CT Lower Extremity **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 338,278

2021 Work RVU: 1.00
2021 NF PE RVU: 3.02
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73701 **Computed tomography, lower extremity; with contrast material(s)**

Global: XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth1 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 47,637

2021 Work RVU: 1.16
2021 NF PE RVU: 4.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.16 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73702 **Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Lower Extremity **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** February 2009 **2019 est Medicare Utilization:** 4,842

2021 Work RVU: 1.22
2021 NF PE RVU: 4.88
2021 Fac PE RVU: NA

RUC Recommendation: 1.22 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73706 **Computed tomographic angiography, lower extremity, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2008 **2019 est Medicare Utilization:** 16,508

2021 Work RVU: 1.90
2021 NF PE RVU: 8.30
2021 Fac PE RVU: NA

RUC Recommendation: Survey for October 2013. Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73718 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s)**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 148,143

2021 Work RVU: 1.35
2021 NF PE RVU: 5.93
2021 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73719 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; with contrast material(s)**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,344

2021 Work RVU: 1.62
2021 NF PE RVU: 6.94
2021 Fac PE RVU: NA

RUC Recommendation: 1.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

73720 **Magnetic resonance (eg, proton) imaging, lower extremity other than joint; without contrast material(s), followed by contrast material(s) and further sequences**

Global: XXX **Issue:** MRI Lower Extremity **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 64,864

2021 Work RVU: 2.15
2021 NF PE RVU: 8.88
2021 Fac PE RVU: NA

RUC Recommendation: 2.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

73721 **Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material**

Global: XXX **Issue:** MRI of Lower Extremity Joint **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 670,662

2021 Work RVU: 1.35
2021 NF PE RVU: 5.11
2021 Fac PE RVU: NA

RUC Recommendation: 1.35 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74000 **Radiologic examination, abdomen; single anteroposterior view**

Global: **Issue:** Abdominal X-Ray **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74010 **Radiologic examination, abdomen; anteroposterior and additional oblique and cone views**

Global: **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74018 **Radiologic examination, abdomen; 1 view**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: February 2016

2019 est Medicare Utilization: 2,153,087

2021 Work RVU: 0.18
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.18

Referred to CPT February 2016

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74019 **Radiologic examination, abdomen; 2 views**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: February 2016

2019 est Medicare Utilization: 429,437

2021 Work RVU: 0.23
2021 NF PE RVU: 0.83
2021 Fac PE RVU: NA

RUC Recommendation: 0.23

Referred to CPT February 2016

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74020 **Radiologic examination, abdomen; complete, including decubitus and/or erect views**

Global: **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: July 2015

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74021 **Radiologic examination, abdomen; 3 or more views**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: February 2016

2019 est Medicare Utilization: 58,811

2021 Work RVU: 0.27
2021 NF PE RVU: 0.96
2021 Fac PE RVU: NA

RUC Recommendation: 0.27

Referred to CPT February 2016

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74022 **Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest**

Global: XXX **Issue:** Abdominal X-Ray **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 08 **Specialty Developing Recommendation:** ACR

First Identified: July 2015

2019 est Medicare Utilization: 283,318

2021 Work RVU: 0.32
2021 NF PE RVU: 1.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.32

Referred to CPT February 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74150 **Computed tomography, abdomen; without contrast material**

Global: XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACR

First Identified: February 2008

2019 est Medicare Utilization: 77,343

2021 Work RVU: 1.19
2021 NF PE RVU: 3.05
2021 Fac PE RVU: NA

RUC Recommendation: Review PE. 0.35

Referred to CPT October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74160 **Computed tomography, abdomen; with contrast material(s)**

Global: XXX **Issue:** CT Abdomen and Pelvis **Screen:** Codes Reported Together 95% or More / MPC List / CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 44 **Specialty Developing Recommendation:** ACR

First Identified: February 2008

2019 est Medicare Utilization: 105,409

2021 Work RVU: 1.27
2021 NF PE RVU: 6.07
2021 Fac PE RVU: NA

RUC Recommendation: 0.42

Referred to CPT October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74170 **Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections**

Global: XXX **Issue:** CT Abdomen **Screen:** Codes Reported Together 95% or More / CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 34 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 107,476

2021 Work RVU: 1.40
2021 NF PE RVU: 6.85
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** October 2009 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74174 **Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** **2019 est Medicare Utilization:** 294,980

2021 Work RVU: 2.20
2021 NF PE RVU: 9.64
2021 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74175 **Computed tomographic angiography, abdomen, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography **Screen:** CMS Fastest Growing / Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2008 **2019 est Medicare Utilization:** 37,638

2021 Work RVU: 1.82
2021 NF PE RVU: 7.68
2021 Fac PE RVU: NA

RUC Recommendation: 1.82 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74176 **Computed tomography, abdomen and pelvis; without contrast material** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 16 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,284,436

2021 Work RVU: 1.74
2021 NF PE RVU: 3.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.74 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74177 **Computed tomography, abdomen and pelvis; with contrast material(s)** **Global:** XXX **Issue:** CT Abdomen and Pelvis **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 44 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,361,910

2021 Work RVU: 1.82
2021 NF PE RVU: 7.79
2021 Fac PE RVU: NA

RUC Recommendation: 1.82 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74178 **Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions** **Global:** XXX **Issue:** CT Abdomen/CT Pelvis **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 16 **Specialty Developing Recommendation:** ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 534,971

2021 Work RVU: 2.01
2021 NF PE RVU: 8.78
2021 Fac PE RVU: NA

RUC Recommendation: 2.01 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74181 **Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 117,420

2021 Work RVU: 1.46
2021 NF PE RVU: 4.86
2021 Fac PE RVU: NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74182 **Magnetic resonance (eg, proton) imaging, abdomen; with contrast material(s)**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 4,286

2021 Work RVU: 1.73
2021 NF PE RVU: 8.19
2021 Fac PE RVU: NA

RUC Recommendation: 1.73 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74183 **Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s), followed by with contrast material(s) and further sequences**

Global: XXX **Issue:** MRI of Abdomen **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:** 354,840

2021 Work RVU: 2.20
2021 NF PE RVU: 8.85
2021 Fac PE RVU: NA

RUC Recommendation: 2.20 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74210 **Radiologic examination, pharynx and/or cervical esophagus, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2016 **2019 est Medicare Utilization:** 1,577

2021 Work RVU: 0.59
2021 NF PE RVU: 2.27
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74220 **Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** April 2016 **2019 est Medicare Utilization:** 196,573

2021 Work RVU: 0.60
2021 NF PE RVU: 2.31
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74221 **Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.70
2021 NF PE RVU: 2.57
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74230 **Radiologic examination, swallowing function, with cineradiography/videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Esophagus **Screen:** CMS-Other - Utilization over 250,000 / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 370,056

2021 Work RVU: 0.53
2021 NF PE RVU: 3.33
2021 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

74240 **Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 53,309

2021 Work RVU: 0.80
2021 NF PE RVU: 2.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74241 **Radiologic examination, gastrointestinal tract, upper; with or without delayed images, with KUB**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 25,415

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74245 **Radiologic examination, gastrointestinal tract, upper; with small intestine, includes multiple serial images**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR

First Identified: October 2017

2019 est Medicare Utilization: 12,946

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

74246 **Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered**

Global: XXX **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR

First Identified: October 2017

2019 est Medicare Utilization: 34,438

2021 Work RVU: 0.90

2021 NF PE RVU: 3.26

2021 Fac PE RVU: NA

RUC Recommendation: 0.90

Referred to CPT May 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

74247 **Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with or without delayed images, with KUB**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR

First Identified: April 2011

2019 est Medicare Utilization: 21,591

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018

Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

74248 **Radiologic small intestine follow-through study, including multiple serial images (list separately in addition to code for primary procedure for upper gi radiologic examination)**

Global: ZZZ **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.70
2021 NF PE RVU: 1.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.70

Referred to CPT February 2019-EC **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

74249 **Radiological examination, gastrointestinal tract, upper, air contrast, with specific high density barium, effervescent agent, with or without glucagon; with small intestine follow-through**

Global: **Issue:** X-Ray Exam – Upper GI **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 12 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 13,972

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

74250 **Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 52,021

2021 Work RVU: 0.81
2021 NF PE RVU: 2.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.81

Referred to CPT May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74251 **Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; double-contrast (eg, high-density barium and air via enteroclysis tube) study, including glucagon, when administered**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 206

2021 Work RVU: 1.17
2021 NF PE RVU: 10.69
2021 Fac PE RVU: NA

RUC Recommendation: 1.17 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74260 **Duodenography, hypotonic**

Global: **Issue:** X-Ray Exam – Small Intestine/Colon **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 24

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74270 **Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR

First Identified: October 2017 **2019 est Medicare Utilization:** 28,934

2021 Work RVU: 1.04
2021 NF PE RVU: 3.56
2021 Fac PE RVU: NA

RUC Recommendation: 1.04 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74280 **Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered**

Global: XXX **Issue:** Lower Gastroinetstinal Tract Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 11 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,205

2021 Work RVU: 1.26
2021 NF PE RVU: 5.41
2021 Fac PE RVU: NA

RUC Recommendation: 1.26 **Referred to CPT** May 2018 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

74300 **Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 29,648

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.32 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

74301 **Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 19 **Specialty Developing Recommendation:** ACR, ACS, SAGES, SIR **First Identified:** October 2018 **2019 est Medicare Utilization:** 63

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74305 **Deleted from CPT**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74320 **Cholangiography, percutaneous, transhepatic, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74327 **Postoperative biliary duct calculus removal, percutaneous via T-tube tract, basket, or snare (eg, Burhenne technique), radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74328 **Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 64,506

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.47 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74329 **Endoscopic catheterization of the pancreatic ductal system, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 2,990

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74330 **Combined endoscopic catheterization of the biliary and pancreatic ductal systems, radiological supervision and interpretation**

Global: XXX **Issue:** X-Rays at Surgery Add-On **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ACR, SAGES **First Identified:** October 2018 **2019 est Medicare Utilization:** 13,859

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

74400 **Urography (pyelography), intravenous, with or without kub, with or without tomography**

Global: XXX **Issue:** Contrast X-Ray Exams **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 31 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 5,180

2021 Work RVU: 0.49
2021 NF PE RVU: 3.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.49 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74420 **Urography, retrograde, with or without kub**

Global: XXX **Issue:** X-Ray Urinary Tract **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 26 **Specialty Developing Recommendation:** ACR, AUA **First Identified:** April 2016 **2019 est Medicare Utilization:** 166,220

2021 Work RVU: 0.52
2021 NF PE RVU: 1.69
2021 Fac PE RVU: NA

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74425 **Urography, antegrade, radiological supervision and interpretation**

Global: XXX **Issue:** Urography **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 18 **Specialty Developing Recommendation:** ACR, AUA, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 3,703

2021 Work RVU: 0.51
2021 NF PE RVU: 3.53
2021 Fac PE RVU: NA

RUC Recommendation: 0.51, editorially revised **Referred to CPT** September 2019 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

74475 **Introduction of intracatheter or catheter into renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

74480 **Introduction of ureteral catheter or stent into ureter through renal pelvis for drainage and/or injection, percutaneous, radiological supervision and interpretation**

Global: **Issue:** Genitourinary Catheter Procedures **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 09 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

74485 **Dilation of ureter(s) or urethra, radiological supervision and interpretation**

Global: XXX **Issue:** Dilation of Urinary Tract **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 1,628

2021 Work RVU: 0.83
2021 NF PE RVU: 2.63
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75561 **Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;**

Global: XXX **Issue:** **Screen:** High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 29,956

2021 Work RVU: 2.60
2021 NF PE RVU: 9.39
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75572 **Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3d image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)**

Global: XXX **Issue:** **Screen:** High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 29,288

2021 Work RVU: 1.75
2021 NF PE RVU: 6.13
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

75574 **Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3d image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)**

Global: XXX **Issue:** **Screen:** CMS Request - Final Rule for 2013 / High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACR, SIR, ACC **First Identified:** May 2013 **2019 est Medicare Utilization:** 86,531

2021 Work RVU: 2.40
2021 NF PE RVU: 9.10
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

75625 **Aortography, abdominal, by serialography, radiological supervision and interpretation**

Global: XXX **Issue:** Abdominal Aortography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 19 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 96,916

2021 Work RVU: 1.44
2021 NF PE RVU: 2.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75630 **Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation**

Global: XXX **Issue:** Abdominal Aortography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 19 **Specialty Developing Recommendation:** ACC, SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 27,465

2021 Work RVU: 2.00
2021 NF PE RVU: 2.62
2021 Fac PE RVU: NA

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75635 **Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing**

Global: XXX **Issue:** CT Angiography of Abdominal Arteries **Screen:** High Volume Growth1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 34 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:** 114,472

2021 Work RVU: 2.40
2021 NF PE RVU: 10.42
2021 Fac PE RVU: NA

RUC Recommendation: 2.40 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

75650 **Angiography, carotid, cervical, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75671 **Angiography, carotid, cerebral, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75680 **Angiography, carotid, cervical, bilateral, radiological supervision and interpretation**

Global: **Issue:** Carotid Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AANS/CNS, ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75710 **Angiography, extremity, unilateral, radiological supervision and interpretation**

Global: XXX **Issue:** Angiography of Extremities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 157,614

2021 Work RVU: 1.75
2021 NF PE RVU: 2.66
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant and review after 2 years of data after publication available. 1.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2021

Status Report: CMS Requests and Relativity Assessment Issues

75716 **Angiography, extremity, bilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Angiography of Extremities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACC, RPA, SCAI, SIR, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:** 74,926

2021 Work RVU: 1.97
2021 NF PE RVU: 2.79
2021 Fac PE RVU: NA

RUC Recommendation: 1.97 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75722 **Angiography, renal, unilateral, selective (including flush aortogram), radiological supervision and interpretation** **Global:** **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75724 **Angiography, renal, bilateral, selective (including flush aortogram), radiological supervision and interpretation** **Global:** **Issue:** Renal Angiography **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, ASNR, AUR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75726 **Angiography, visceral, selective or supraselective (with or without flush aortogram), radiological supervision and interpretation**

Global: XXX **Issue:** Angiography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 20 **Specialty Developing Recommendation:** SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 41,396

2021 Work RVU: 2.05
2021 NF PE RVU: 3.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.05 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75774 **Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Angiography **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 20 **Specialty Developing Recommendation:** SCAI, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 77,363

2021 Work RVU: 1.01
2021 NF PE RVU: 1.93
2021 Fac PE RVU: NA

RUC Recommendation: 1.01 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

75790 **Deleted from CPT**

Global: **Issue:** Arteriovenous Shunt Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 9 **Specialty Developing Recommendation:** SVS, SIR, ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75791 **Angiography, arteriovenous shunt (eg, dialysis patient fistula/graft), complete evaluation of dialysis access, including fluoroscopy, image documentation and report (includes injections of contrast and all necessary imaging from the arterial anastomosis and adjacent artery through entire venous outflow including the inferior or superior vena cava), radiological supervision and interpretation**

Global: **Issue:** Dialysis Circuit -1 **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 14 **Specialty Developing Recommendation:** ACR, RPA, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75820 **Venography, extremity, unilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Venography **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 23,689

2021 Work RVU: 1.05
2021 NF PE RVU: 2.30
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

75822 **Venography, extremity, bilateral, radiological supervision and interpretation** **Global:** XXX **Issue:** Venography **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 10,692

2021 Work RVU: 1.48
2021 NF PE RVU: 2.51
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75885 **Percutaneous transhepatic portography with hemodynamic evaluation, radiological supervision and interpretation**

Global: XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 348

2021 Work RVU: 1.44
2021 NF PE RVU: 2.64
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

75887 **Percutaneous transhepatic portography without hemodynamic evaluation, radiological supervision and interpretation**

Global: XXX **Issue:** Interventional Radiology Procedures **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 21 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** NA **2019 est Medicare Utilization:** 525

2021 Work RVU: 1.44
2021 NF PE RVU: 2.68
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

75894 **Transcatheter therapy, embolization, any method, radiological supervision and interpretation**

Global: XXX **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 9,539

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** RAW will assess Oct 2018 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75896 **Transcatheter therapy, infusion, other than for thrombolysis, radiological supervision and interpretation**

Global: **Issue:** Intracranial Endovascular Intervention **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 09 **Specialty Developing Recommendation:** AANS/CNS, ACR, ASNR, SCAI, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 February 2015 May 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75898 **Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion, other than for thrombolysis**

Global: XXX **Issue:** Intracranial Endovascular Intervention **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AANS/CNS, ACR, ASNR, SCAI, SIR **First Identified:** February 2010 **2019 est Medicare Utilization:** 11,637

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant **Referred to CPT** February 2014 February 2015 **Result:** Contractor Price

Referred to CPT Asst ☑ **Published in CPT Asst:** September 2019

75940 **Percutaneous placement of IVC filter, radiological supervision and interpretation**

Global: **Issue:** Major Vein Revision **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75945 **Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; initial vessel**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75946 **Intravascular ultrasound (non-coronary vessel), radiological supervision and interpretation; each additional non-coronary vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Intravascular Ultrasound **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 07 **Specialty Developing Recommendation:** ACC,SCAI, SIR, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75952 **Endovascular repair of infrarenal abdominal aortic aneurysm or dissection, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75953 **Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal aortic or iliac artery aneurysm, pseudoaneurysm, or dissection, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75954 **Endovascular repair of iliac artery aneurysm, pseudoaneurysm, arteriovenous malformation, or trauma, using ilio-iliac tube endoprosthesis, radiological supervision and interpretation**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75960 **Transcatheter introduction of intravascular stent(s) (except coronary, carotid, vertebral, iliac, and lower extremity artery), percutaneous and/or open, radiological supervision and interpretation, each vessel**

Global: **Issue:** RAW **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 27 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75961 **Transcatheter retrieval, percutaneous, of intravascular foreign body (eg, fractured venous or arterial catheter), radiological supervision and interpretation**

Global: **Issue:** Transcatheter Procedures **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75962 **Transluminal balloon angioplasty, peripheral artery other than renal, or other visceral artery, iliac or lower extremity, radiological supervision and interpretation**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75964 **Transluminal balloon angioplasty, each additional peripheral artery other than renal or other visceral artery, iliac or lower extremity, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75966 **Transluminal balloon angioplasty, renal or other visceral artery, radiological supervision and interpretation**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** January 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75968 **Transluminal balloon angioplasty, each additional visceral artery, radiological supervision and interpretation (List separately in addition to code for primary procedure)**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** January 2015 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75978 **Transluminal balloon angioplasty, venous (eg, subclavian stenosis), radiological supervision and interpretation**

Global: **Issue:** Open and Percutaneous Transluminal Angioplasty **Screen:** CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 15 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75980 **Percutaneous transhepatic biliary drainage with contrast monitoring, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75982 **Percutaneous placement of drainage catheter for combined internal and external biliary drainage or of a drainage stent for internal biliary drainage in patients with an inoperable mechanical biliary obstruction, radiological supervision and interpretation**

Global: **Issue:** Percutaneous Biliary Procedures Bundling **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 06 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

75984 **Change of percutaneous tube or drainage catheter with contrast monitoring (eg, genitourinary system, abscess), radiological supervision and interpretation**

Global: XXX **Issue:** Introduction of Catheter or Stent **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 17 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 20,664

2021 Work RVU: 0.83
2021 NF PE RVU: 2.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** RAW will assess Oct 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75992 **Deleted from CPT** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75993 **Deleted from CPT** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75994 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

75995 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

75996 **Revised to Category III** **Global:** **Issue:** Transluminal Arthrectomy **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 57 **Specialty Developing Recommendation:** SIR, ACR, SVS **First Identified:** April 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

76000 **Fluoroscopy (separate procedure), up to 1 hour physician or other qualified health care professional time** **Global:** XXX **Issue:** Fluoroscopy **Screen:** Low Value-Billed in Multiple Units / CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 27 **Specialty Developing Recommendation:** ACR, APMA **First Identified:** October 2010 **2019 est Medicare Utilization:** 118,492

2021 Work RVU: 0.30
2021 NF PE RVU: 0.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

76001 **Fluoroscopy, physician or other qualified health care professional time more than 1 hour, assisting a nonradiologic physician or other qualified health care professional (eg, nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)** **Global:** **Issue:** Fluoroscopy **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 27 **Specialty Developing Recommendation:** ACR **First Identified:** October 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76098 **Radiological examination, surgical specimen** **Global:** XXX **Issue:** X-Ray Exam Specimen **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 21 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 68,182

2021 Work RVU: 0.31
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

76100 **Radiologic examination, single plane body section (eg, tomography), other than with urography** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 5,269

2021 Work RVU: 0.58
2021 NF PE RVU: 2.12
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

76101 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 2

2021 Work RVU: 0.58
2021 NF PE RVU: 2.30
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

76102 **Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; bilateral** **Global:** XXX **Issue:** Fluroscopy **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 27 **Specialty Developing Recommendation:** ACR, ISIS **First Identified:** April 2009 **2019 est Medicare Utilization:** 2,408

2021 Work RVU: 0.58
2021 NF PE RVU: 4.65
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76376 **3d rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation**

Global: XXX **Issue:** 3D Rendering **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 23 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** April 2017 **2019 est Medicare Utilization:** 276,317

2021 Work RVU: 0.20
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76377 **3d rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation**

Global: XXX **Issue:** 3D Rendering with Interpretation and Report **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASNR **First Identified:** July 2019 **2019 est Medicare Utilization:** 190,343

2021 Work RVU: 0.79
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.79 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76510 **Ophthalmic ultrasound, diagnostic; b-scan and quantitative a-scan performed during the same patient encounter**

Global: XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 14,435

2021 Work RVU: 0.70
2021 NF PE RVU: 1.41
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76511 **Ophthalmic ultrasound, diagnostic; quantitative a-scan only**

Global: XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 4,208

2021 Work RVU: 0.64
2021 NF PE RVU: 1.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.64 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76512 **Ophthalmic ultrasound, diagnostic; b-scan (with or without superimposed non-quantitative a-scan)**

Global: XXX **Issue:** Opthalmic Ultrasound **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 23 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 220,526

2021 Work RVU: 0.56
2021 NF PE RVU: 0.85
2021 Fac PE RVU: NA

RUC Recommendation: 0.56 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76513 **Ophthalmic ultrasound, diagnostic; anterior segment ultrasound, immersion (water bath) b-scan or high resolution biomicroscopy, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmic Ultrasound Anterior Segment **Screen:** High Volume Growth1 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 17 **Specialty Developing Recommendation:** AAO, AOA (optometric), ASCRS **First Identified:** February 2008 **2019 est Medicare Utilization:** 26,263

2021 Work RVU: 0.60
2021 NF PE RVU: 1.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 and CPT Assistant article published **Referred to CPT** September 2019 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Apr 2013

Status Report: CMS Requests and Relativity Assessment Issues

76514 **Ophthalmic ultrasound, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness)**

Global: XXX **Issue:** Echo Exam of Eye Thickness **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 12 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2017 **2019 est Medicare Utilization:** 488,963

2021 Work RVU: 0.14
2021 NF PE RVU: 0.18
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76516 **Ophthalmic biometry by ultrasound echography, a-scan;**

Global: XXX **Issue:** Opthalmic Biometry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 36 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,403

2021 Work RVU: 0.40
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76519 **Ophthalmic biometry by ultrasound echography, a-scan; with intraocular lens power calculation**

Global: XXX **Issue:** Opthalmic Biometry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 36 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:** 187,253

2021 Work RVU: 0.54
2021 NF PE RVU: 1.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76536 **Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation**

Global: XXX **Issue:** Soft Tissue Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** ACR, ASNR, TES, AACE **First Identified:** October 2008 **2019 est Medicare Utilization:** 945,181

2021 Work RVU: 0.56
2021 NF PE RVU: 2.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76604 **Ultrasound, chest (includes mediastinum), real time with image documentation** **Global:** XXX **Issue:** Ultrasound Exam - Chest **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 24 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 106,091

2021 Work RVU: 0.59
2021 NF PE RVU: 1.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

76641 **Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; complete** **Global:** XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:** 647,984

2021 Work RVU: 0.73
2021 NF PE RVU: 2.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.73 **Referred to CPT** October 2013 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

76642 **Ultrasound, breast, unilateral, real time with image documentation, including axilla when performed; limited** **Global:** XXX **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** January 2014 **2019 est Medicare Utilization:** 769,119

2021 Work RVU: 0.68
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: 0.68 **Referred to CPT** October 2013 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

76645 **Ultrasound, breast(s) (unilateral or bilateral), real time with image documentation** **Global:** **Issue:** Breast Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76700 **Ultrasound, abdominal, real time with image documentation; complete** **Global:** XXX **Issue:** Ultrasound **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 908,859

2021 Work RVU: 0.81
2021 NF PE RVU: 2.71
2021 Fac PE RVU: NA

RUC Recommendation: 0.81 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76705 **Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)** **Global:** XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR, ASBS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,100,059

2021 Work RVU: 0.59
2021 NF PE RVU: 2.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

76706 **Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (aaa)** **Global:** XXX **Issue:** Abdominal Aorta Ultrasound Screening **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** May 2015 **2019 est Medicare Utilization:** 159,273

2021 Work RVU: 0.55
2021 NF PE RVU: 2.62
2021 Fac PE RVU: NA

RUC Recommendation: 0.55 **Referred to CPT** May 2015 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2017

76770 **Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; complete** **Global:** XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,345,427

2021 Work RVU: 0.74
2021 NF PE RVU: 2.51
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76775 **Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 522,183

2021 Work RVU: 0.58
2021 NF PE RVU: 1.09
2021 Fac PE RVU: NA

RUC Recommendation: 0.58 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76819 **Fetal biophysical profile; without non-stress testing**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 12,225

2021 Work RVU: 0.77
2021 NF PE RVU: 1.71
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

76830 **Ultrasound, transvaginal**

Global: XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 442,342

2021 Work RVU: 0.69
2021 NF PE RVU: 2.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76856 **Ultrasound, pelvic (nonobstetric), real time with image documentation; complete**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2011 **2019 est Medicare Utilization:** 429,962

2021 Work RVU: 0.69
2021 NF PE RVU: 2.48
2021 Fac PE RVU: NA

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76857 **Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)**

Global: XXX **Issue:** Ultrasound **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 13 **Specialty Developing Recommendation:** ACR **First Identified:** April 2013 **2019 est Medicare Utilization:** 205,984

2021 Work RVU: 0.50
2021 NF PE RVU: 0.87
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

76870 **Ultrasound, scrotum and contents**

Global: XXX **Issue:** Ultrasound Exam - Scrotum **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 28 **Specialty Developing Recommendation:** ACR, AUA **First Identified:** April 2016 **2019 est Medicare Utilization:** 147,467

2021 Work RVU: 0.64
2021 NF PE RVU: 2.39
2021 Fac PE RVU: NA

RUC Recommendation: 0.64 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76872 **Ultrasound, transrectal;**

Global: XXX **Issue:** Transvaginal and Transrectal Ultrasound **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 44 **Specialty Developing Recommendation:** ACOG, ACR, AUA **First Identified:** September 2011 **2019 est Medicare Utilization:** 212,765

2021 Work RVU: 0.69
2021 NF PE RVU: 4.79
2021 Fac PE RVU: NA

RUC Recommendation: 0.69 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76880 **Deleted from CPT**

Global: **Issue:** Lower Extremity Ultrasound **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 26 **Specialty Developing Recommendation:** APMA, ACR **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76881 **Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation**

Global: XXX **Issue:** Neuromuscular Ultrasound **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAN, AANEM, AAPM&R, ACR, ACRh, APMA **First Identified:** April 2010 **2019 est Medicare Utilization:** 196,753

2021 Work RVU: 0.63
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: Survey **Referred to CPT** June 2017 **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Winter 2011; Apr 2016

76882 **Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation**

Global: XXX **Issue:** Neuromuscular Ultrasound **Screen:** CMS Fastest Growing / New Technology/New Services **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAN, AANEM, AAPM&R, ACR, ACRh, APMA **First Identified:** April 2010 **2019 est Medicare Utilization:** 288,120

2021 Work RVU: 0.49
2021 NF PE RVU: 1.13
2021 Fac PE RVU: NA

RUC Recommendation: Survey **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☑ **Published in CPT Asst:** Clinical Examples of Radiology Summer and Winter 2011; Apr 2016

76930 **Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation**

Global: **Issue:** Pericardiocentesis and Pericardial Drainage **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 04 **Specialty Developing Recommendation:** ACC **First Identified:** July 2013 **2019 est Medicare Utilization:** 2,662

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76932 **Ultrasonic guidance for endomyocardial biopsy, imaging supervision and interpretation**

Global: YYY **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 34 **Specialty Developing Recommendation:** ACC **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,241

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.67 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76936 **Ultrasound guided compression repair of arterial pseudoaneurysm or arteriovenous fistulae (includes diagnostic ultrasound evaluation, compression of lesion and imaging)**

Global: XXX **Issue:** RAW **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** July 2013 **2019 est Medicare Utilization:** 810

2021 Work RVU: 1.99
2021 NF PE RVU: 5.68
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76937 **Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PICC Line Procedures **Screen:** Identified in RUC review of other services **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2019 est Medicare Utilization:** 637,782

2021 Work RVU: 0.30
2021 NF PE RVU: 0.80
2021 Fac PE RVU: NA

RUC Recommendation: Survey in 2 years (April 2022) **Referred to CPT** **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76940 **Ultrasound guidance for, and monitoring of, parenchymal tissue ablation**

Global: YYY **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 29 **Specialty Developing Recommendation:** ACS, ACR, SIR **First Identified:** July 2013 **2019 est Medicare Utilization:** 1,403

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76942 **Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation**

Global: XXX **Issue:** Somatic Nerve Injections **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, ACR, SIR, SIS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,178,266

2021 Work RVU: 0.67
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.67 **Referred to CPT** May 2021 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76948 **Ultrasonic guidance for aspiration of ova, imaging supervision and interpretation**

Global: XXX **Issue:** Echo Guidance for Ova Aspiration **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 25 **Specialty Developing Recommendation:** ACOG **First Identified:** July 2013 **2019 est Medicare Utilization:** 3

2021 Work RVU: 0.67
2021 NF PE RVU: 1.65
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76950 **Ultrasonic guidance for placement of radiation therapy fields**

Global: **Issue:** Ultrasound Guidance **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 34 **Specialty Developing Recommendation:**

First Identified: February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

76965 **Ultrasonic guidance for interstitial radioelement application**

Global: XXX **Issue:** Ultrasound Guidance **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** NO INTERESET

First Identified: July 2013 **2019 est Medicare Utilization:** 6,316

2021 Work RVU: 1.34
2021 NF PE RVU: 1.31
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

76970 **Ultrasound study follow-up (specify)**

Global: **Issue:** IMRT with Ultrasound Guidance **Screen:** High Volume Growth1 / CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** ACS, ACR, AACE

First Identified: February 2008 **2019 est Medicare Utilization:** 25,085

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

76998 **Ultrasonic guidance, intraoperative**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS **First Identified:** January 2019 **2019 est Medicare Utilization:** 29,381

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT **Referred to CPT** February 2022 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

77001 **Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** PICC Line Procedures **Screen:** MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 09 **Specialty Developing Recommendation:** AANS, AANEM, AAPM, AAPM&R, ACR, ASIPP, ASA, ASNR, CNS, ISIS, NASS **First Identified:** January 2012 **2019 est Medicare Utilization:** 310,854

2021 Work RVU: 0.38
2021 NF PE RVU: 2.58
2021 Fac PE RVU: NA

RUC Recommendation: 0.38 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77002 **Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Somatic Nerve Injections **Screen:** MPC List / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2015 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, ACR, SIR, SIS **First Identified:** January 2012 **2019 est Medicare Utilization:** 528,759

2021 Work RVU: 0.54
2021 NF PE RVU: 2.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** October 2015 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77003 **Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Somatic Nerve Injections **Screen:** MPC List / CMS Request - Final Rule for 2013 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 05 **Specialty Developing Recommendation:** AAPM, AAPM&R, ACR, SIR, SIS **First Identified:** October 2010 **2019 est Medicare Utilization:** 77,998

2021 Work RVU: 0.60
2021 NF PE RVU: 2.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** October 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77011 **Computed tomography guidance for stereotactic localization**

Global: XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 15 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** **2019 est Medicare Utilization:** 4,582

2021 Work RVU: 1.21
2021 NF PE RVU: 5.59
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77012 **Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation**

Global: XXX **Issue:** Lung Biopsy-CT Guidance Bundle **Screen:** CMS-Other - Utilization over 100,000 / Codes Reported Together 75%or More-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 05 **Specialty Developing Recommendation:** ACR, SIR **First Identified:** April 2016 **2019 est Medicare Utilization:** 210,656

2021 Work RVU: 1.50
2021 NF PE RVU: 2.73
2021 Fac PE RVU: NA

RUC Recommendation: Bundled 32405 and 77012. 1.50 **Referred to CPT** February 2019 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77014 **Computed tomography guidance for placement of radiation therapy fields** **Global:** XXX **Issue:** IMRT with CT Guidance **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO, ACR **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,401,373

2021 Work RVU: 0.85
2021 NF PE RVU: 2.72
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77031 **Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation** **Global:** **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77032 **Mammographic guidance for needle placement, breast (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation** **Global:** **Issue:** Breast Biopsy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 04 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77046 **Magnetic resonance imaging, breast, without contrast material; unilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 367

2021 Work RVU: 1.45
2021 NF PE RVU: 5.44
2021 Fac PE RVU: NA

RUC Recommendation: 1.45

Referred to CPT June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77047 **Magnetic resonance imaging, breast, without contrast material; bilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 4,029

2021 Work RVU: 1.60
2021 NF PE RVU: 5.48
2021 Fac PE RVU: NA

RUC Recommendation: 1.60

Referred to CPT June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77048 **Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (cad real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 1,164

2021 Work RVU: 2.10
2021 NF PE RVU: 8.88
2021 Fac PE RVU: NA

RUC Recommendation: 2.10

Referred to CPT June 2017 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77049 **Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (cad real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral**

Global: XXX **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR

First Identified: June 2017

2019 est Medicare Utilization: 87,710

2021 Work RVU: 2.30
2021 NF PE RVU: 8.91
2021 Fac PE RVU: NA

RUC Recommendation: 2.30

Referred to CPT June 2017 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

77051 **Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; diagnostic mammography (List separately in addition to code for primary procedure)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** CMS-Other - Utilization over 250,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR

First Identified:

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77052 **Computer-aided detection (computer algorithm analysis of digital image data for lesion detection) with further review for interpretation, with or without digitization of film radiographic images; screening mammography (List separately in addition to code for primary procedure)**

Global: **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR

First Identified: October 2010

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77055 **Mammography; unilateral**

Global:

Issue: Mammography-Computer Aided Detection Bundling

Screen: CMS-Other - Utilization over 250,000 / Final Rule for 2015

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab: 20

Specialty Developing Recommendation: ACR

First Identified: January 2014

2019 est Medicare Utilization:

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77056 **Mammography; bilateral**

Global:

Issue: Mammography-Computer Aided Detection Bundling

Screen: CMS-Other - Utilization over 250,000 / Final Rule for 2015

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab: 20

Specialty Developing Recommendation: ACR

First Identified: January 2014

2019 est Medicare Utilization:

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77057 **Screening mammography, bilateral (2-view study of each breast)**

Global:

Issue: Mammography-Computer Aided Detection Bundling

Screen: CMS-Other - Utilization over 250,000 / Final Rule for 2015

Complete? Yes

Most Recent RUC Meeting: January 2016

Tab: 20

Specialty Developing Recommendation: ACR

First Identified: January 2014

2019 est Medicare Utilization:

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2015

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77058 **Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral**

Global: **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77059 **Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral**

Global: **Issue:** Breast MRI with Computer-Aided Detection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 06 **Specialty Developing Recommendation:** ACR **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77065 **Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral**

Global: XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 765,901

2021 Work RVU: 0.81
2021 NF PE RVU: 2.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.81 **Referred to CPT** October 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

77066 **Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral**

Global: XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 612,243

2021 Work RVU: 1.00
2021 NF PE RVU: 3.70
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** October 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77067 **Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed**

Global: XXX **Issue:** Mammography-Computer Aided Detection Bundling **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** October 2015 **2019 est Medicare Utilization:** 6,106,768

2021 Work RVU: 0.76
2021 NF PE RVU: 3.04
2021 Fac PE RVU: NA

RUC Recommendation: 0.76 **Referred to CPT** October 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77073 **Bone length studies (orthoroentgenogram, scanogram)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** AAOS, ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 57,827

2021 Work RVU: 0.26
2021 NF PE RVU: 1.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77074 **Radiologic examination, osseous survey; limited (eg, for metastases)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 4,891

2021 Work RVU: 0.44
2021 NF PE RVU: 1.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.44 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77075 **Radiologic examination, osseous survey; complete (axial and appendicular skeleton)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 44,120

2021 Work RVU: 0.55
2021 NF PE RVU: 2.29
2021 Fac PE RVU: NA

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77076 **Radiologic examination, osseous survey, infant**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 50

2021 Work RVU: 0.70
2021 NF PE RVU: 2.36
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77077 **Joint survey, single view, 2 or more joints (specify)**

Global: XXX **Issue:** X-Ray Exam - Bone **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 25 **Specialty Developing Recommendation:** ACR **First Identified:** October 2017 **2019 est Medicare Utilization:** 39,322

2021 Work RVU: 0.33
2021 NF PE RVU: 1.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.33 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

77079 **Computed tomography, bone mineral density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)**

Global: **Issue:** CT Bone Density Study **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** ACR, AAFP, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77080 **Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine)**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** CMS Request - Final Rule for 2012 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,624,321

2021 Work RVU: 0.20
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** May 2013 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77081 **Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; appendicular skeleton (peripheral) (eg, radius, wrist, heel)**

Global: XXX **Issue:** Dual-energy X-Ray Absorptiometry (DXA) **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 25 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 42,987

2021 Work RVU: 0.20
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77082 **Dual-energy X-ray absorptiometry (DXA), bone density study, 1 or more sites; vertebral fracture assessment**

Global: **Issue:** Dual Energy X-Ray **Screen:** CMS Request - Final Rule for 2012 / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77083 **Radiographic absorptiometry (eg, photodensitometry, radiogrammetry), 1 or more sites**

Global: **Issue:** Radiographic Absorptiometry **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** ACR, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77085 **Dual-energy x-ray absorptiometry (dxa), bone density study, 1 or more sites; axial skeleton (eg, hips, pelvis, spine), including vertebral fracture assessment**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** **2019 est Medicare Utilization:** 110,730

2021 Work RVU: 0.30
2021 NF PE RVU: 1.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77086 **Vertebral fracture assessment via dual-energy x-ray absorptiometry (dxa)**

Global: XXX **Issue:** Dual Energy X-Ray **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 07 **Specialty Developing Recommendation:** AACE, ACNM, ACR, ACRh, SNMMI, TES **First Identified:** **2019 est Medicare Utilization:** 1,925

2021 Work RVU: 0.17
2021 NF PE RVU: 0.79
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** May 2013 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77261 **Therapeutic radiology treatment planning; simple**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 37 **Specialty Developing Recommendation:** ASTRO **First Identified:** July 2015 **2019 est Medicare Utilization:** 9,135

2021 Work RVU: 1.30
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.67

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77262 **Therapeutic radiology treatment planning; intermediate**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 37 **Specialty Developing Recommendation:** ASTRO **First Identified:** July 2015 **2019 est Medicare Utilization:** 3,526

2021 Work RVU: 2.00
2021 NF PE RVU: 0.99
2021 Fac PE RVU: 0.99

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77263 **Therapeutic radiology treatment planning; complex**

Global: XXX **Issue:** Radiation Therapy Planning **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 37 **Specialty Developing Recommendation:** ASTRO **First Identified:** July 2015 **2019 est Medicare Utilization:** 297,484

2021 Work RVU: 3.14
2021 NF PE RVU: 1.51
2021 Fac PE RVU: 1.51

RUC Recommendation: 3.14 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77280 **Therapeutic radiology simulation-aided field setting; simple**

Global: XXX **Issue:** Set Radiation Therapy Field **Screen:** Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2011 **2019 est Medicare Utilization:** 370,105

2021 Work RVU: 0.70
2021 NF PE RVU: 7.55
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77285 **Therapeutic radiology simulation-aided field setting; intermediate**

Global: XXX **Issue:** Respiratory Motion Management Simulation **Screen:** Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,612

2021 Work RVU: 1.05
2021 NF PE RVU: 12.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77290 **Therapeutic radiology simulation-aided field setting; complex**

Global: XXX **Issue:** Respiratory Motion Management Simulation **Screen:** MPC List / Harvard Valued - Utilization over 30,000 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 210,211

2021 Work RVU: 1.56
2021 NF PE RVU: 12.74
2021 Fac PE RVU: NA

RUC Recommendation: 1.56 **Referred to CPT** October 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77293 **Respiratory motion management simulation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Respiratory Motion Management Simulation **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:** 31,536

2021 Work RVU: 2.00
2021 NF PE RVU: 10.91
2021 Fac PE RVU: NA

RUC Recommendation: 2.00 **Referred to CPT** October 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77295 **3-dimensional radiotherapy plan, including dose-volume histograms**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 14 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2011 **2019 est Medicare Utilization:** 142,124

2021 Work RVU: 4.29
2021 NF PE RVU: 9.58
2021 Fac PE RVU: NA

RUC Recommendation: 4.29 **Referred to CPT** October 2012, October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77300 **Basic radiation dosimetry calculation, central axis depth dose calculation, tdf, nsd, gap calculation, off axis factor, tissue inhomogeneity factors, calculation of non-ionizing radiation surface and depth dose, as required during course of treatment, only when prescribed by the treating physician**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** MPC List / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,349,820

2021 Work RVU: 0.62
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.62 **Referred to CPT** February 2014, October 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77301 **Intensity modulated radiotherapy plan, including dose-volume histograms for target and critical structure partial tolerance specifications**

Global: XXX **Issue:** IMRT - PE Only **Screen:** CMS Fastest Growing / CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes1 / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 28 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:** 143,270

2021 Work RVU: 7.99
2021 NF PE RVU: 46.91
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 7.99. CPT Assistant article published.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2009

77305 **Teletherapy, isodose plan (whether hand or computer calculated); simple (1 or 2 parallel opposed unmodified ports directed to a single area of interest)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77306 **Teletherapy isodose plan; simple (1 or 2 unmodified ports directed to a single area of interest), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,027

2021 Work RVU: 1.40
2021 NF PE RVU: 2.84
2021 Fac PE RVU: NA

RUC Recommendation: 1.40

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77307 **Teletherapy isodose plan; complex (multiple treatment areas, tangential ports, the use of wedges, blocking, rotational beam, or special beam considerations), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 40,701

2021 Work RVU: 2.90
2021 NF PE RVU: 5.33
2021 Fac PE RVU: NA

RUC Recommendation: 2.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77310 **Teletherapy, isodose plan (whether hand or computer calculated); intermediate (3 or more treatment ports directed to a single area of interest)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77315 **Teletherapy, isodose plan (whether hand or computer calculated); complex (mantle or inverted Y, tangential ports, the use of wedges, compensators, complex blocking, rotational beam, or special beam considerations)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77316 **Brachytherapy isodose plan; simple (calculation[s] made from 1 to 4 sources, or remote afterloading brachytherapy, 1 channel), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012

2019 est Medicare Utilization: 4,610

2021 Work RVU: 1.40
2021 NF PE RVU: 5.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

77317 **Brachytherapy isodose plan; intermediate (calculation[s] made from 5 to 10 sources, or remote afterloading brachytherapy, 2-12 channels), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2012

2019 est Medicare Utilization: 3,179

2021 Work RVU: 1.83
2021 NF PE RVU: 6.96
2021 Fac PE RVU: NA

RUC Recommendation: 1.83

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

77318 **Brachytherapy isodose plan; complex (calculation[s] made from over 10 sources, or remote afterloading brachytherapy, over 12 channels), includes basic dosimetry calculation(s)**

Global: XXX **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 / RUC Request **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:**

First Identified: October 2012

2019 est Medicare Utilization: 5,949

2021 Work RVU: 2.90
2021 NF PE RVU: 9.61
2021 Fac PE RVU: NA

RUC Recommendation: 2.90

Referred to CPT February 2014
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

77326 **Brachytherapy isodose plan; simple (calculation made from single plane, 1 to 4 sources/ribbon application, remote afterloading brachytherapy, 1 to 8 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77327 **Brachytherapy isodose plan; intermediate (multiplane dosage calculations, application involving 5 to 10 sources/ribbons, remote afterloading brachytherapy, 9 to 12 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77328 **Brachytherapy isodose plan; complex (multiplane isodose plan, volume implant calculations, over 10 sources/ribbons used, special spatial reconstruction, remote afterloading brachytherapy, over 12 sources)**

Global: **Issue:** Isodose Calculation with Isodose Planning Bundle **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 20 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77332 **Treatment devices, design and construction; simple (simple block, simple bolus)**

Global: XXX **Issue:** RAW **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2015 **2019 est Medicare Utilization:** 75,801

2021 Work RVU: 0.45
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77333 **Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)**

Global: XXX **Issue:** RAW **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** April 2015 **2019 est Medicare Utilization:** 12,128

2021 Work RVU: 0.75
2021 NF PE RVU: 3.09
2021 Fac PE RVU: NA

RUC Recommendation: 0.84 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

77334 **Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)**

Global: XXX **Issue:** **Screen:** MPC List / RUC request / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2010 **2019 est Medicare Utilization:** 845,243

2021 Work RVU: 1.15
2021 NF PE RVU: 2.47
2021 Fac PE RVU: NA

RUC Recommendation: 1.24 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77336 **Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy**

Global: XXX **Issue:** Continuing Medical Physics Consultation-PE Only **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 31 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:** 412,038

2021 Work RVU: 0.00
2021 NF PE RVU: 2.31
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77338 **Multi-leaf collimator (mlc) device(s) for intensity modulated radiation therapy (imrt), design and construction per imrt plan**

Global: XXX **Issue:** IMRT - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 28 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:** 165,179

2021 Work RVU: 4.29
2021 NF PE RVU: 9.27
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77371 **Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source cobalt 60 based**

Global: XXX **Issue:** Radiation Treatment Delivery, Stereotactic Radiosurgery **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 30 **Specialty Developing Recommendation:** ASTRO **First Identified:** NA **2019 est Medicare Utilization:** 100

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77372 **Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:** 818

2021 Work RVU: 0.00
2021 NF PE RVU: 30.62
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77373 **Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 18 **Specialty Developing Recommendation:** ACR, ASTRO, ACRO **First Identified:** July 2012 **2019 est Medicare Utilization:** 33,144

2021 Work RVU: 0.00
2021 NF PE RVU: 33.38
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77385 **Intensity modulated radiation treatment delivery (imrt), includes guidance and tracking, when performed; simple**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77386 **Intensity modulated radiation treatment delivery (imrt), includes guidance and tracking, when performed; complex**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77387 **Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.58 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77401 **Radiation treatment delivery, superficial and/or ortho voltage, per day**

Global: XXX **Issue:** Radiation Treatement Delivery (PE Only) **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 31 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 221,049

2021 Work RVU: 0.00
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** May 2019 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77402 **Radiation treatment delivery, >=1 mev; simple**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 and Feburary 2014 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77403 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77404 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77406 **Radiation treatment delivery, single treatment area, single port or parallel opposed ports, simple blocks or no blocks; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77407 **Radiation treatment delivery, >=1 mev; intermediate**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

77408 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77409 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77411 **Radiation treatment delivery, 2 separate treatment areas, 3 or more ports on a single treatment area, use of multiple blocks; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77412 **Radiation treatment delivery, >=1 mev; complex**

Global: XXX **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only, revised introductory guidelines **Referred to CPT** October 2013 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77413 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77414 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 MeV**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77416 **Radiation treatment delivery, 3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 MeV or greater**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77418 **Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** CMS Fastest Growing / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Nov 2009 and Q&A - Mar 2010

77421 **Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy**

Global: **Issue:** Radiation Treatment Delivery - PE Only **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 14 **Specialty Developing Recommendation:** ACRO, ASTRO **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77422 **High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking**

Global: **Issue:** High Energy Neutron Radiation Treatment **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 35 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77423 **High energy neutron radiation treatment delivery, 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)**

Global: XXX **Issue:** High Energy Neutron Radiation Treatment **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 35 **Specialty Developing Recommendation:** AAOS, ASPS, ASSH **First Identified:** November 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Contractor Price **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

77427 **Radiation treatment management, 5 treatments**

Global: XXX **Issue:** Radiation Treatment Management **Screen:** Site of Service Anomaly / High Level E/M in Global Period **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ASTRO **First Identified:** September 2007 **2019 est Medicare Utilization:** 1,043,579

2021 Work RVU: 3.37
2021 NF PE RVU: 1.88
2021 Fac PE RVU: 1.88

RUC Recommendation: 3.45. Remove from high E/M screen. **Referred to CPT** June 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77435 **Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 38,142

2021 Work RVU: 11.87
2021 NF PE RVU: 5.81
2021 Fac PE RVU: 5.81

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77470 **Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)**

Global: XXX **Issue:** Special Radiation Treatment **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 41 **Specialty Developing Recommendation:** ASTRO **First Identified:** July 2015 **2019 est Medicare Utilization:** 91,885

2021 Work RVU: 2.03
2021 NF PE RVU: 1.73
2021 Fac PE RVU: NA

RUC Recommendation: 2.03 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77520 **Proton treatment delivery; simple, without compensation**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2018 **2019 est Medicare Utilization:** 256

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77522 **Proton treatment delivery; simple, with compensation**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** January 2018 **2019 est Medicare Utilization:** 15,881

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77523 **Proton treatment delivery; intermediate**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** High Volume Growth4 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2016 **2019 est Medicare Utilization:** 47,302

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77525 **Proton treatment delivery; complex**

Global: XXX **Issue:** Proton Beam Treatment Delivery (PE Only) **Screen:** Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 19 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2018 **2019 est Medicare Utilization:** 20,144

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

77600 **Hyperthermia, externally generated; superficial (ie, heating to a depth of 4 cm or less)**

Global: XXX **Issue:** Hyperthermia - PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** October 2012 **2019 est Medicare Utilization:** 5,464

2021 Work RVU: 1.31
2021 NF PE RVU: 12.92
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77767 **Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter up to 2.0 cm or 1 channel**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 5,362

2021 Work RVU: 1.05
2021 NF PE RVU: 6.09
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77768 **Remote afterloading high dose rate radionuclide skin surface brachytherapy, includes basic dosimetry, when performed; lesion diameter over 2.0 cm and 2 or more channels, or multiple lesions**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 7,665

2021 Work RVU: 1.40
2021 NF PE RVU: 9.17
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77770 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 1 channel**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 17,117

2021 Work RVU: 1.95
2021 NF PE RVU: 8.07
2021 Fac PE RVU: NA

RUC Recommendation: 1.95 **Referred to CPT** October 2014 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77771 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; 2-12 channels**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 17,697

2021 Work RVU: 3.80
2021 NF PE RVU: 13.63
2021 Fac PE RVU: NA

RUC Recommendation: 3.80 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77772 **Remote afterloading high dose rate radionuclide interstitial or intracavitary brachytherapy, includes basic dosimetry, when performed; over 12 channels**

Global: XXX **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO, ACRO **First Identified:** October 2014 **2019 est Medicare Utilization:** 4,164

2021 Work RVU: 5.40
2021 NF PE RVU: 20.66
2021 Fac PE RVU: NA

RUC Recommendation: 5.40 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

77776 **Interstitial radiation source application; simple**

Global: **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77777 **Interstitial radiation source application; intermediate**

Global: **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 17 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77778 **Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed**

Global: 000 **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:** 4,806

2021 Work RVU: 8.78
2021 NF PE RVU: 16.56
2021 Fac PE RVU: NA

RUC Recommendation: 8.78 **Referred to CPT** February 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

77781 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77782 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77784 **Deleted from CPT**

Global: **Issue:** Brachytherapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ASTRO **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

77785 **Remote afterloading high dose rate radionuclide brachytherapy; 1 channel**

Global: **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

77786 **Remote afterloading high dose rate radionuclide brachytherapy; 2-12 channels** **Global:** **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77787 **Remote afterloading high dose rate radionuclide brachytherapy; over 12 channels** **Global:** **Issue:** Surface Radionuclide High Does Rate Brachytherapy **Screen:** High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services with Stand-Alone PE Procedure Time / Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASTRO **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

77790 **Supervision, handling, loading of radiation source** **Global:** XXX **Issue:** Interstitial Radiation Source Codes **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ACR, ASTRO, SIR **First Identified:** October 2012 **2019 est Medicare Utilization:** 145

2021 Work RVU: 0.00
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 **Referred to CPT** February 2015 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78000 **Thyroid uptake; single determination**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78001 **Thyroid uptake; multiple determinations**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78003 **Thyroid uptake; stimulation, suppression or discharge (not including initial uptake studies)**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78006 **Thyroid imaging, with uptake; single determination**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78007 **Thyroid imaging, with uptake; multiple determinations**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78010 **Thyroid imaging; only**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78011 **Thyroid imaging; with vascular flow**

Global: **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78012 **Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 1,653

2021 Work RVU: 0.19
2021 NF PE RVU: 2.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78013 **Thyroid imaging (including vascular flow, when performed);**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 1,711

2021 Work RVU: 0.37
2021 NF PE RVU: 5.33
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78014 **Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**

Global: XXX **Issue:** Thyroid Uptake/Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 22 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** **2019 est Medicare Utilization:** 18,954

2021 Work RVU: 0.50
2021 NF PE RVU: 6.47
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78070 **Parathyroid planar imaging (including subtraction, when performed);**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 13,220

2021 Work RVU: 0.80
2021 NF PE RVU: 7.80
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

Status Report: CMS Requests and Relativity Assessment Issues

78071 **Parathyroid planar imaging (including subtraction, when performed); with tomographic (spect)**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 8,974

2021 Work RVU: 1.20
2021 NF PE RVU: 9.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78072 **Parathyroid planar imaging (including subtraction, when performed); with tomographic (spect), and concurrently acquired computed tomography (ct) for anatomical localization**

Global: XXX **Issue:** Parathyroid Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT 2013 Utilization Review **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 12,267

2021 Work RVU: 1.60
2021 NF PE RVU: 11.34
2021 Fac PE RVU: NA

RUC Recommendation: 1.60 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78223 **Hepatobiliary ductal system imaging, including gallbladder, with or without pharmacologic intervention, with or without quantitative measurement of gallbladder function**

Global: **Issue:** Hepatobiliary Ductal System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78226 **Hepatobiliary system imaging, including gallbladder when present;**

Global: XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2019 est Medicare Utilization:** 61,197

2021 Work RVU: 0.74
2021 NF PE RVU: 8.80
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78227 **Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed**

Global: XXX **Issue:** Hepatobiliary System Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 12 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** **2019 est Medicare Utilization:** 64,389

2021 Work RVU: 0.90
2021 NF PE RVU: 11.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78265 **Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit**

Global: XXX **Issue:** Colon Transit Imaging **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 18 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** April 2015 **2019 est Medicare Utilization:** 1,303

2021 Work RVU: 0.98
2021 NF PE RVU: 10.46
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2015

78266 **Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days**

Global: XXX **Issue:** Colon Transit Imaging **Screen:** New code for CPT 2016. **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 18 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** April 2015 **2019 est Medicare Utilization:** 313

2021 Work RVU: 1.08
2021 NF PE RVU: 11.62
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published **Referred to CPT** **Result:** Not Part of RAW

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2015

Status Report: CMS Requests and Relativity Assessment Issues

78278 **Acute gastrointestinal blood loss imaging**

Global: XXX **Issue:** Acute GI Blood Loss Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 34 **Specialty Developing Recommendation:** ACR, SNM, ACNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 26,257

2021 Work RVU: 0.99
2021 NF PE RVU: 9.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.99 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78300 **Bone and/or joint imaging; limited area**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 6,808

2021 Work RVU: 0.62
2021 NF PE RVU: 6.06
2021 Fac PE RVU: NA

RUC Recommendation: 0.62 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78305 **Bone and/or joint imaging; multiple areas**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,645

2021 Work RVU: 0.83
2021 NF PE RVU: 7.27
2021 Fac PE RVU: NA

RUC Recommendation: 0.83 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78306 **Bone and/or joint imaging; whole body**

Global: XXX **Issue:** Bone Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 38 **Specialty Developing Recommendation:** ACNM, ACR, SNMMI **First Identified:** July 2015 **2019 est Medicare Utilization:** 262,283

2021 Work RVU: 0.86
2021 NF PE RVU: 7.86
2021 Fac PE RVU: NA

RUC Recommendation: 0.86 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78429 **Myocardial imaging, positron emission tomography (pet), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.76 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78430 **Myocardial imaging, positron emission tomography (pet), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.67 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78431 **Myocardial imaging, positron emission tomography (pet), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78432 **Myocardial imaging, positron emission tomography (pet), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.07 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78433 **Myocardial imaging, positron emission tomography (pet), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.26 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78434 **Absolute quantitation of myocardial blood flow (aqmbf), positron emission tomography (pet), rest and pharmacologic stress (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.63 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78451 **Myocardial perfusion imaging, tomographic (spect) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 35,912

2021 Work RVU: 1.38
2021 NF PE RVU: 8.53
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78452 **Myocardial perfusion imaging, tomographic (spect) (including attenuation correction, qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 1,787,846

2021 Work RVU: 1.62
2021 NF PE RVU: 12.21
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78453 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 1,518

2021 Work RVU: 1.00
2021 NF PE RVU: 7.72
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78454 **Myocardial perfusion imaging, planar (including qualitative or quantitative wall motion, ejection fraction by first pass or gated technique, additional quantification, when performed); multiple studies, at rest and/or stress (exercise or pharmacologic) and/or redistribution and/or rest reinjection**

Global: XXX **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** NA **2019 est Medicare Utilization:** 10,009

2021 Work RVU: 1.34
2021 NF PE RVU: 11.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.34 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

78459 **Myocardial imaging, positron emission tomography (pet), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:** 3,214

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.61 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

78460 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78461 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78464 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78465 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78472 **Cardiac blood pool imaging, gated equilibrium; planar, single study at rest or stress (exercise and/or pharmacologic), wall motion study plus ejection fraction, with or without additional quantitative processing**

Global: XXX **Issue:** Cardiac Blood Pool Imaging **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 35 **Specialty Developing Recommendation:** ACC, ACR, SNM, ACNM **First Identified:** April 2011 **2019 est Medicare Utilization:** 18,051

2021 Work RVU: 0.98
2021 NF PE RVU: 5.64
2021 Fac PE RVU: NA

RUC Recommendation: 0.98 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78478 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78480 **Deleted from CPT**

Global: **Issue:** Myocardial Perfusion Imaging **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 16 **Specialty Developing Recommendation:** SNM, ACR, ASNC, ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2008 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78491 **Myocardial imaging, positron emission tomography (pet), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** May 2018 **2019 est Medicare Utilization:** 1,809

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.56 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78492 **Myocardial imaging, positron emission tomography (pet), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)**

Global: XXX **Issue:** Myocardial PET **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 13 **Specialty Developing Recommendation:** ACC, ACR, ACNM, SNMMI **First Identified:** October 2016 **2019 est Medicare Utilization:** 179,360

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** May 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

78579 **Pulmonary ventilation imaging (eg, aerosol or gas)**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 360

2021 Work RVU: 0.49
2021 NF PE RVU: 4.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.49 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78580 **Pulmonary perfusion imaging (eg, particulate)**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,224

2021 Work RVU: 0.74
2021 NF PE RVU: 6.14
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

78582 **Pulmonary ventilation (eg, aerosol or gas) and perfusion imaging**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 165,031

2021 Work RVU: 1.07
2021 NF PE RVU: 8.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.07 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78584 **Pulmonary perfusion imaging, particulate, with ventilation; single breath**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78585 **Pulmonary perfusion imaging, particulate, with ventilation; rebreathing and washout, with or without single breath**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78586 **Pulmonary ventilation imaging, aerosol; single projection**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78587 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78588 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78591 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78593 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78594 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78596 **Deleted from CPT**

Global: **Issue:** Pulmonary Perfusion Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

78597 **Quantitative differential pulmonary perfusion, including imaging when performed**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,640

2021 Work RVU: 0.75
2021 NF PE RVU: 5.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

78598 **Quantitative differential pulmonary perfusion and ventilation (eg, aerosol or gas), including imaging when performed**

Global: XXX **Issue:** Pulmonary Imaging **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 13 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** February 2010 **2019 est Medicare Utilization:** 3,383

2021 Work RVU: 0.85
2021 NF PE RVU: 8.01
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

78803 **Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (spect), single area (eg, head, neck, chest, pelvis), single day imaging**

Global: XXX **Issue:** RAW **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 14 **Specialty Developing Recommendation:** ACR, ACNM, SNM **First Identified:** January 2016 **2019 est Medicare Utilization:** 11,736

2021 Work RVU: 1.09
2021 NF PE RVU: 10.20
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2016

78815 **Positron emission tomography (pet) with concurrently acquired computed tomography (ct) for attenuation correction and anatomical localization imaging; skull base to mid-thigh**

Global: XXX **Issue:** **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:** ACR, SNM **First Identified:** October 2010 **2019 est Medicare Utilization:** 604,627

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Reaffirmed RUC recommendation **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

79101 **Radiopharmaceutical therapy, by intravenous administration**

Global: XXX **Issue:** Radiopharmaceutical Therapy **Screen:** Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** SNM, ACR **First Identified:** October 2009 **2019 est Medicare Utilization:** 12,142

2021 Work RVU: 1.96
2021 NF PE RVU: 2.28
2021 Fac PE RVU: NA

RUC Recommendation: Article published Feb 2012 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Feb 2012

80500 **Clinical pathology consultation; limited, without review of patient's history and medical records**

Global: XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2019 **2019 est Medicare Utilization:** 21,998

2021 Work RVU: 0.37
2021 NF PE RVU: 0.25
2021 Fac PE RVU: 0.16

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

80502 **Clinical pathology consultation; comprehensive, for a complex diagnostic problem, with review of patient's history and medical records**

Global: XXX **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:** 13,114

2021 Work RVU: 1.33
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.60

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

80503 **Pathology clinical consultation; for a clinical problem, with limited review of patient's history and medical records and straightforward medical decision making when using time for code selection, 5-20 minutes of total time is spent on the date of the consultation.**

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 0.50 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

80504 **Pathology clinical consultation; for a moderately complex clinical problem, with review of patient's history and medical records and moderate level of medical decision making when using time for code selection, 21-40 minutes of total time is spent on the date of the consultation.**

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 0.91 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

80505 **Pathology clinical consultation; for a highly complex clinical problem, with comprehensive review of patient's history and medical records and high level of medical decision making when using time for code selection, 41-60 minutes of total time is spent on the date of the consultation.**

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 1.80 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

80506 **Pathology clinical consultation; prolonged service, each additional 30 minutes (list separately in addition to code for primary procedure)**

Global: **Issue:** Pathology Clinical Consult **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 20 **Specialty Developing Recommendation:** CAP **First Identified:** January 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 0.80 **Referred to CPT** October 2020 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

85060 **Blood smear, peripheral, interpretation by physician with written report**

Global: XXX **Issue:** Blood Smear Interpretation **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 30 **Specialty Developing Recommendation:** CAP **First Identified:** April 2016 **2019 est Medicare Utilization:** 185,409

2021 Work RVU: 0.45
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.22

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

85097 **Bone marrow, smear interpretation**

Global: XXX **Issue:** Bone Marrow Interpretation **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 31 **Specialty Developing Recommendation:** CAP **First Identified:** April 2016 **2019 est Medicare Utilization:** 140,727

2021 Work RVU: 0.94
2021 NF PE RVU: 1.01
2021 Fac PE RVU: 0.42

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

85390 **Fibrinolysins or coagulopathy screen, interpretation and report**

Global: XXX **Issue:** Fibrinolysins Screen **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 26 **Specialty Developing Recommendation:** **First Identified:** April 2017 **2019 est Medicare Utilization:** 34,588

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88104 **Cytopathology, fluids, washings or brushings, except cervical or vaginal; smears with interpretation**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 65,152

2021 Work RVU: 0.56
2021 NF PE RVU: 1.35
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88106 **Cytopathology, fluids, washings or brushings, except cervical or vaginal; simple filter method with interpretation**

Global: XXX **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,360

2021 Work RVU: 0.37
2021 NF PE RVU: 1.53
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88107 **Deleted from CPT**

Global: **Issue:** Cytopathology **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 17 **Specialty Developing Recommendation:** AUR, ASC, CAP **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88108 **Cytopathology, concentration technique, smears and interpretation (eg, saccomanno technique)**

Global: XXX **Issue:** Cytopathology Concentration Technique-PE Only **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** ACR, CAP

First Identified: February 2010 **2019 est Medicare Utilization:** 229,625

2021 Work RVU: 0.44
2021 NF PE RVU: 1.37
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

88112 **Cytopathology, selective cellular enhancement technique with interpretation (eg, liquid based slide preparation method), except cervical or vaginal**

Global: XXX **Issue:** Cytopathology Concentration Technique-PE Only **Screen:** CMS High Expenditure Procedural Codes1 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:** ACR, CAP

First Identified: September 2011 **2019 est Medicare Utilization:** 886,295

2021 Work RVU: 0.56
2021 NF PE RVU: 1.36
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. 0.56

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

88120 **Cytopathology, in situ hybridization (eg, fish), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual**

Global: XXX **Issue:** RAW review **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:**

First Identified: November 2012 **2019 est Medicare Utilization:** 49,876

2021 Work RVU: 1.20
2021 NF PE RVU: 16.90
2021 Fac PE RVU: NA

RUC Recommendation: Utilization shift is appropriate.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

88121 **Cytopathology, in situ hybridization (eg, fish), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology**

Global: XXX **Issue:** RAW review **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:**

First Identified: November 2012 **2019 est Medicare Utilization:** 28,769

2021 Work RVU: 1.00
2021 NF PE RVU: 12.06
2021 Fac PE RVU: NA

RUC Recommendation: Utilization shift is appropriate.

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

88141 **Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP

First Identified: October 2017 **2019 est Medicare Utilization:** 55,857

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

88160 **Cytopathology, smears, any other source; screening and interpretation**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:**

First Identified: April 2015 **2019 est Medicare Utilization:** 8,020

2021 Work RVU: 0.50
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

Status Report: CMS Requests and Relativity Assessment Issues

88161 **Cytopathology, smears, any other source; preparation, screening and interpretation**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:**

First Identified: April 2015

2019 est Medicare Utilization: 4,156

2021 Work RVU: 0.50
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

88162 **Cytopathology, smears, any other source; extended study involving over 5 slides and/or multiple stains**

Global: XXX **Issue:** Cytopathology Concentration Technique - PE Only **Screen:** CMS Request - Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 36 **Specialty Developing Recommendation:**

First Identified: April 2015

2019 est Medicare Utilization: 1,306

2021 Work RVU: 0.76
2021 NF PE RVU: 2.20
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

88184 **Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; first marker**

Global: XXX **Issue:** Flow Cytometry **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** **Specialty Developing Recommendation:** CAP

First Identified: July 2015

2019 est Medicare Utilization: 104,681

2021 Work RVU: 0.00
2021 NF PE RVU: 1.98
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. Removed from FR 2018 as misvalued.

Referred to CPT

Result: PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88185 **Flow cytometry, cell surface, cytoplasmic, or nuclear marker, technical component only; each additional marker (list separately in addition to code for first marker)**

Global: ZZZ **Issue:** Flow Cytometry **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** **Specialty Developing Recommendation:** CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,918,080

2021 Work RVU: 0.00
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs. Removed from FR 2018 as misvalued.

Referred to CPT **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

88187 **Flow cytometry, interpretation; 2 to 8 markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 42 **Specialty Developing Recommendation:** CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 42,225

2021 Work RVU: 0.74
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.27

RUC Recommendation: 0.74

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88188 **Flow cytometry, interpretation; 9 to 15 markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 42 **Specialty Developing Recommendation:** CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 38,197

2021 Work RVU: 1.20
2021 NF PE RVU: 0.55
2021 Fac PE RVU: 0.55

RUC Recommendation: 1.40

Referred to CPT **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88189 **Flow cytometry, interpretation; 16 or more markers**

Global: XXX **Issue:** Flow Cytometry Interpretation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 42 **Specialty Developing Recommendation:** CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 222,162

2021 Work RVU: 1.70
2021 NF PE RVU: 0.65
2021 Fac PE RVU: 0.65

RUC Recommendation: 1.70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88300 **Level i - surgical pathology, gross examination only**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / Low Value-Billed in Multiple Units / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 207,562

2021 Work RVU: 0.08
2021 NF PE RVU: 0.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.08 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88302 **Level ii - surgical pathology, gross and microscopic examination appendix, incidental fallopian tube, sterilization fingers/toes, amputation, traumatic foreskin, newborn hernia sac, any location hydrocele sac nerve skin, plastic repair sympathetic ganglion testis, castration vaginal mucosa, incidental vas deferens, sterilization**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 75,443

2021 Work RVU: 0.13
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 0.13 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88304 **Level iii - surgical pathology, gross and microscopic examination abortion, induced abscess aneurysm - arterial/ventricular anus, tag appendix, other than incidental artery, atheromatous plaque bartholin's gland cyst bone fragment(s), other than pathologic fracture bursa/synovial cyst carpal tunnel tissue cartilage, shavings cholesteatoma colon, colostomy stoma conjunctiva - biopsy/pterygium cornea diverticulum - esophagus/small intestine dupuytren's contracture tissue femoral head, other than fracture fissure/fistula foreskin, other than newborn gallbladder ganglion cyst hematoma hemorrhoids hydatid of morgagni intervertebral disc joint, loose body meniscus mucocele, salivary neuroma - morton's/traumatic pilonidal cyst/sinus polyps, inflammatory - nasal/sinusoidal skin - cyst/tag/debridement soft tissue, debridement soft tissue, lipoma spermatocele tendon/tendon sheath testicular appendage thrombus or embolus tonsil and/or adenoids varicocele vas deferens, other than sterilization vein, varicosity**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** October 2008 **2019 est Medicare Utilization:** 967,907

2021 Work RVU: 0.22
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.22 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88305 **Level iv - surgical pathology, gross and microscopic examination abortion - spontaneous/missed artery, biopsy bone marrow, biopsy bone exostosis brain/meninges, other than for tumor resection breast, biopsy, not requiring microscopic evaluation of surgical margins breast, reduction mammoplasty bronchus, biopsy cell block, any source cervix, biopsy colon, biopsy duodenum, biopsy endocervix, curettings/biopsy endometrium, curettings/biopsy esophagus, biopsy extremity, amputation, traumatic fallopian tube, biopsy fallopian tube, ectopic pregnancy femoral head, fracture fingers/toes, amputation, non-traumatic gingiva/oral mucosa, biopsy heart valve joint, resection kidney, biopsy larynx, biopsy leiomyoma(s), uterine myomectomy - without uterus lip, biopsy/wedge resection lung, transbronchial biopsy lymph node, biopsy muscle, biopsy nasal mucosa, biopsy nasopharynx/oropharynx, biopsy nerve, biopsy odontogenic/dental cyst omentum, biopsy ovary with or without tube, non-neoplastic ovary, biopsy/wedge resection parathyroid gland peritoneum, biopsy pituitary tumor placenta, other than third trimester pleura/pericardium - biopsy/tissue polyp, cervical/endometrial polyp, colorectal polyp, stomach/small intestine prostate, needle biopsy prostate, tur salivary gland, biopsy sinus, paranasal biopsy skin, other than cyst/tag/debridement/plastic repair small intestine, biopsy soft tissue, other than tumor/mass/lipoma/debridement spleen stomach, biopsy synovium testis, other than tumor/biopsy/castration thyroglossal duct/brachial cleft cyst tongue, biopsy tonsil, biopsy trachea, biopsy ureter, biopsy urethra, biopsy urinary bladder, biopsy uterus, with or without tubes and ovaries, for prolapse vagina, biopsy vulva/labia, biopsy**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request - Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** October 2008 **2019 est Medicare Utilization:** 17,561,979

2021 Work RVU: 0.75
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88307 **Level v - surgical pathology, gross and microscopic examination adrenal, resection bone - biopsy/curettings bone fragment(s), pathologic fracture brain, biopsy brain/meninges, tumor resection breast, excision of lesion, requiring microscopic evaluation of surgical margins breast, mastectomy - partial/simple cervix, conization colon, segmental resection, other than for tumor extremity, amputation, non-traumatic eye, enucleation kidney, partial/total nephrectomy larynx, partial/total resection liver, biopsy - needle/wedge liver, partial resection lung, wedge biopsy lymph nodes, regional resection mediastinum, mass myocardium, biopsy odontogenic tumor ovary with or without tube, neoplastic pancreas, biopsy placenta, third trimester prostate, except radical resection salivary gland sentinel lymph node small intestine, resection, other than for tumor soft tissue mass (except lipoma) - biopsy/simple excision stomach - subtotal/total resection, other than for tumor testis, biopsy thymus, tumor thyroid, total/lobe ureter, resection urinary bladder, tur uterus, with or without tubes and ovaries, other than neoplastic/prolapse**

Global: XXX **Issue:** Pathology Consultations **Screen:** Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 983,152

2021 Work RVU: 1.59
2021 NF PE RVU: 6.65
2021 Fac PE RVU: NA

RUC Recommendation: 1.59 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88309 **Level vi - surgical pathology, gross and microscopic examination bone resection breast, mastectomy - with regional lymph nodes colon, segmental resection for tumor colon, total resection esophagus, partial/total resection extremity, disarticulation fetus, with dissection larynx, partial/total resection - with regional lymph nodes lung - total/lobe/segment resection pancreas, total/subtotal resection prostate, radical resection small intestine, resection for tumor soft tissue tumor, extensive resection stomach - subtotal/total resection for tumor testis, tumor tongue/tonsil -resection for tumor urinary bladder, partial/total resection uterus, with or without tubes and ovaries, neoplastic vulva, total/subtotal resection**

Global: XXX **Issue:** Pathology Services **Screen:** Havard Valued - Utilization over 1 Million / CMS Request- Final Rule for 2012 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 24 **Specialty Developing Recommendation:** AAD, AGA, CAP, ASGE **First Identified:** February 2009 **2019 est Medicare Utilization:** 150,124

2021 Work RVU: 2.80
2021 NF PE RVU: 9.77
2021 Fac PE RVU: NA

RUC Recommendation: 2.80 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88312 **Special stain including interpretation and report; group i for microorganisms (eg, acid fast, methenamine silver)**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,383,233

2021 Work RVU: 0.54
2021 NF PE RVU: 2.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88313 **Special stain including interpretation and report; group ii, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,362,216

2021 Work RVU: 0.24
2021 NF PE RVU: 2.08
2021 Fac PE RVU: NA

RUC Recommendation: 0.24 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

88314 **Special stain including interpretation and report; histochemical stain on frozen tissue block (list separately in addition to code for primary procedure)**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** February 2009 **2019 est Medicare Utilization:** 21,474

2021 Work RVU: 0.45
2021 NF PE RVU: 2.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** June 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88318 **Deleted from CPT**

Global: **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 22 **Specialty Developing Recommendation:** CAP, AAD **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88319 **Special stain including interpretation and report; group iii, for enzyme constituents**

Global: XXX **Issue:** Special Stains **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 33 **Specialty Developing Recommendation:** CAP **First Identified:** **2019 est Medicare Utilization:** 17,807

2021 Work RVU: 0.53
2021 NF PE RVU: 3.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** June 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88321 **Consultation and report on referred slides prepared elsewhere**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 182,148

2021 Work RVU: 1.63
2021 NF PE RVU: 1.12
2021 Fac PE RVU: 0.71

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88323 **Consultation and report on referred material requiring preparation of slides**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 35,000

2021 Work RVU: 1.83
2021 NF PE RVU: 1.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.83 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88325 **Consultation, comprehensive, with review of records and specimens, with report on referred material**

Global: XXX **Issue:** Microslide Consultation **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 43 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** July 2015 **2019 est Medicare Utilization:** 11,656

2021 Work RVU: 2.85
2021 NF PE RVU: 1.79
2021 Fac PE RVU: 1.06

RUC Recommendation: 2.85 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

88329 **Pathology consultation during surgery;**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 18 **Specialty Developing Recommendation:** CAP **First Identified:** February 2010 **2019 est Medicare Utilization:** 27,870

2021 Work RVU: 0.67
2021 NF PE RVU: 0.99
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.67 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88331 **Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 448,638

2021 Work RVU: 1.19
2021 NF PE RVU: 1.78
2021 Fac PE RVU: NA

RUC Recommendation: 1.19 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88332 **Pathology consultation during surgery; each additional tissue block with frozen section(s) (list separately in addition to code for primary procedure)**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 18 **Specialty Developing Recommendation:** CAP **First Identified:** October 2009 **2019 est Medicare Utilization:** 163,257

2021 Work RVU: 0.59
2021 NF PE RVU: 0.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.59 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88333 **Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), initial site**

Global: XXX **Issue:** Pathology Consultation During Surgery **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 39 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 69,359

2021 Work RVU: 1.20
2021 NF PE RVU: 1.53
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88334 **Pathology consultation during surgery; cytologic examination (eg, touch prep, squash prep), each additional site (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Pathology Consultation During Surgery **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 39 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 31,996

2021 Work RVU: 0.73
2021 NF PE RVU: 0.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.73 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

88341 **Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain procedure (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:** 3,097,983

2021 Work RVU: 0.56
2021 NF PE RVU: 2.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.65 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88342 **Immunohistochemistry or immunocytochemistry, per specimen; initial single antibody stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS-Other - Utilization over 500,000 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** April 2011 **2019 est Medicare Utilization:** 2,040,539

2021 Work RVU: 0.70
2021 NF PE RVU: 2.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** May 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88343 **Immunohistochemistry or immunocytochemistry, each separately identifiable antibody per block, cytologic preparation, or hematologic smear; each additional separately identifiable antibody per slide (List separately in addition to code for primary procedure)**

Global: **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88344 **Immunohistochemistry or immunocytochemistry, per specimen; each multiplex antibody stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** November 2013 **2019 est Medicare Utilization:** 132,224

2021 Work RVU: 0.77
2021 NF PE RVU: 4.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.77 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88346 **Immunofluorescence, per specimen; initial single antibody stain procedure** **Global:** XXX **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,000

2021 Work RVU: 0.74
2021 NF PE RVU: 3.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.74 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88347 **Immunofluorescent study, each antibody; indirect method** **Global:** **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** October 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88348 **Electron microscopy, diagnostic** **Global:** XXX **Issue:** Electron Microscopy-PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 14 **Specialty Developing Recommendation:** CAP **First Identified:** October 2012 **2019 est Medicare Utilization:** 17,170

2021 Work RVU: 1.51
2021 NF PE RVU: 10.80
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88349 **Electron microscopy; scanning**

Global: **Issue:** Electron Microscopy-PE Only **Screen:** Services with Stand-Alone PE Procedure Time **Complete?** Yes

Most Recent RUC Meeting: October 2013 **Tab:** 14 **Specialty Developing Recommendation:** CAP **First Identified:** October 2012 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** Oct 2013 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

88350 **Immunofluorescence, per specimen; each additional single antibody stain procedure (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunofluorescent Studies **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 17 **Specialty Developing Recommendation:** CAP, ASC **First Identified:** October 2014 **2019 est Medicare Utilization:** 260,841

2021 Work RVU: 0.59
2021 NF PE RVU: 2.56
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2014 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88356 **Morphometric analysis; nerve**

Global: XXX **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 37 **Specialty Developing Recommendation:** ASCP, CAP **First Identified:** April 2013 **2019 est Medicare Utilization:** 15,440

2021 Work RVU: 2.80
2021 NF PE RVU: 4.11
2021 Fac PE RVU: NA

RUC Recommendation: 2.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88360 **Morphometric analysis, tumor immunohistochemistry (eg, her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; manual**

Global: XXX **Issue:** Tumor Immunohistochemistry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 506,136

2021 Work RVU: 0.85
2021 NF PE RVU: 2.71
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88361 **Morphometric analysis, tumor immunohistochemistry (eg, her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure; using computer-assisted technology**

Global: XXX **Issue:** Tumor Immunohistochemistry **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 40 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2015 **2019 est Medicare Utilization:** 169,281

2021 Work RVU: 0.95
2021 NF PE RVU: 2.59
2021 Fac PE RVU: NA

RUC Recommendation: 0.95 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88364 **In situ hybridization (eg, fish), per specimen; each additional single probe stain procedure (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** November 2013 **2019 est Medicare Utilization:** 28,908

2021 Work RVU: 0.70
2021 NF PE RVU: 3.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88365 **In situ hybridization (eg, fish), per specimen; initial single probe stain procedure** **Global:** XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP **First Identified:** September 2011 **2019 est Medicare Utilization:** 48,038

2021 Work RVU: 0.88
2021 NF PE RVU: 4.41
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

88366 **In situ hybridization (eg, fish), per specimen; each multiplex probe stain procedure** **Global:** XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** May 2013 **2019 est Medicare Utilization:** 2,322

2021 Work RVU: 1.24
2021 NF PE RVU: 7.13
2021 Fac PE RVU: NA

RUC Recommendation: 1.24 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88367 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure** **Global:** XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 18 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** September 2011 **2019 est Medicare Utilization:** 4,914

2021 Work RVU: 0.73
2021 NF PE RVU: 2.57
2021 Fac PE RVU: NA

RUC Recommendation: 0.86 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

Status Report: CMS Requests and Relativity Assessment Issues

88368 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 18 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** September 2011 **2019 est Medicare Utilization:** 21,780

2021 Work RVU: 0.88
2021 NF PE RVU: 3.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2011 & May 2012

88373 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each additional single probe stain procedure (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** November 2013 **2019 est Medicare Utilization:** 6,229

2021 Work RVU: 0.58
2021 NF PE RVU: 1.51
2021 Fac PE RVU: NA

RUC Recommendation: 0.86 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

88374 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; each multiplex probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 21 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** **2019 est Medicare Utilization:** 113,039

2021 Work RVU: 0.93
2021 NF PE RVU: 9.15
2021 Fac PE RVU: NA

RUC Recommendation: 1.04 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

88377 **Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; each multiplex probe stain procedure**

Global: XXX **Issue:** Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) **Screen:** CMS Request - Final Rule for 2012 / CMS Request - Final Rule for 2013 / PE Units Screen **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 24 **Specialty Developing Recommendation:** CAP, ASCP, ASC **First Identified:** May 2013 **2019 est Medicare Utilization:** 152,595

2021 Work RVU: 1.40
2021 NF PE RVU: 10.73
2021 Fac PE RVU: NA

RUC Recommendation: 1.40 **Referred to CPT** May 2013 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

90460 **Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2019 est Medicare Utilization:** 301

2021 Work RVU: 0.17
2021 NF PE RVU: 0.31
2021 Fac PE RVU: NA

RUC Recommendation: 0.24 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90461 **Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2019 est Medicare Utilization:** 58

2021 Work RVU: 0.15
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90465 **Deleted from CPT**

Global: **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90467 **Deleted from CPT**

Global: **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** AAP **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90471 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Fastest Growing / CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** February 2008 **2019 est Medicare Utilization:** 282,357

2021 Work RVU: 0.17

2021 NF PE RVU: 0.31

2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90472 **Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Request – Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** February 2008 **2019 est Medicare Utilization:** 22,524

2021 Work RVU: 0.15
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

90473 **Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** NA **2019 est Medicare Utilization:** 3

2021 Work RVU: 0.17
2021 NF PE RVU: 0.31
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

90474 **Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Immunization Administration **Screen:** CMS Request - Practice Expense Review / CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** NA **2019 est Medicare Utilization:** 1

2021 Work RVU: 0.15
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90785 **Interactive complexity (list separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 / High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 408,566

2021 Work RVU: 0.33
2021 NF PE RVU: 0.09
2021 Fac PE RVU: 0.04

RUC Recommendation: Refer to CPT Review in 3 years (Oct 2023). 0.33 **Referred to CPT** October 2020 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90791 **Psychiatric diagnostic evaluation**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 917,143

2021 Work RVU: 3.84
2021 NF PE RVU: 1.20
2021 Fac PE RVU: 0.50

RUC Recommendation: 3.00 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90792 **Psychiatric diagnostic evaluation with medical services**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 586,327

2021 Work RVU: 4.16
2021 NF PE RVU: 1.47
2021 Fac PE RVU: 0.75

RUC Recommendation: 3.25 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90801 **Psychiatric diagnostic interview examination**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90805 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient; with medical evaluation and management services**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90806 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90808 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90818 **Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an inpatient hospital, partial hospital or residential care setting, approximately 45 to 50 minutes face-to-face with the patient;**

Global: **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:**

First Identified: September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90832 **Psychotherapy, 30 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW

First Identified: April 2013 **2019 est Medicare Utilization:** 2,306,870

2021 Work RVU: 1.70
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.22

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90833 **Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,401,042

2021 Work RVU: 1.50
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.27

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90834 **Psychotherapy, 45 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 4,939,452

2021 Work RVU: 2.24
2021 NF PE RVU: 0.63
2021 Fac PE RVU: 0.28

RUC Recommendation: 2.00 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90836 **Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 510,888

2021 Work RVU: 1.90
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.34

RUC Recommendation: 1.90 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90837 **Psychotherapy, 60 minutes with patient**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,027,217

2021 Work RVU: 3.31
2021 NF PE RVU: 0.93
2021 Fac PE RVU: 0.42

RUC Recommendation: 3.00 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90838 **Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (list separately in addition to the code for primary procedure)**

Global: ZZZ **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 100,884

2021 Work RVU: 2.50
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.46

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

90839 **Psychotherapy for crisis; first 60 minutes**

Global: XXX **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 35 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 23,040

2021 Work RVU: 3.13
2021 NF PE RVU: 0.90
2021 Fac PE RVU: 0.41

RUC Recommendation: 3.13 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90840 **Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service)**

Global: ZZZ **Issue:** Psychotherapy for Crisis and Interactive Complexity **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 35 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 6,284

2021 Work RVU: 1.50
2021 NF PE RVU: 0.42
2021 Fac PE RVU: 0.19

RUC Recommendation: 1.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90845 **Psychoanalysis**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2011 **Tab:** **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 5,591

2021 Work RVU: 2.10
2021 NF PE RVU: 0.62
2021 Fac PE RVU: 0.31

RUC Recommendation: 2.10 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90846 **Family psychotherapy (without the patient present), 50 minutes**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 21,975

2021 Work RVU: 2.40
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.33

RUC Recommendation: 2.40 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90847 **Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes**

Global: XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 178,166

2021 Work RVU: 2.50
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.33

RUC Recommendation: 2.50 **Referred to CPT** February 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90853 **Group psychotherapy (other than of a multiple-family group)** **Global:** XXX **Issue:** Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 26 **Specialty Developing Recommendation:** APA, APA (HCPAC), NASW **First Identified:** April 2013 **2019 est Medicare Utilization:** 906,163

2021 Work RVU: 0.59
2021 NF PE RVU: 0.18
2021 Fac PE RVU: 0.08

RUC Recommendation: 0.59 **Referred to CPT** February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

90862 **Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy** **Global:** **Issue:** RAW review **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

90863 **Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (list separately in addition to the code for primary procedure)** **Global:** XXX **Issue:** Pharmacologic Management with Psychotherapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 40 **Specialty Developing Recommendation:** APA (HCPAC) **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU: 0.48
2021 NF PE RVU: 0.23
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.48 **Referred to CPT** February 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90868 **Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent delivery and management, per session**

Global: 000 **Issue:** **Screen:** Contractor Priced High Volume **Complete?** No

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:**

First Identified: January 2018 **2019 est Medicare Utilization:** 238,754

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review in 2 years (Oct 2020)

Referred to CPT **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

90870 **Electroconvulsive therapy (includes necessary monitoring)**

Global: 000 **Issue:** Electroconvulsive Therapy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 41 **Specialty Developing Recommendation:** APA

First Identified: October 2009 **2019 est Medicare Utilization:** 126,401

2021 Work RVU: 2.50
2021 NF PE RVU: 2.49
2021 Fac PE RVU: 0.51

RUC Recommendation: 2.50

Referred to CPT **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90911 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry**

Global: **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 15 **Specialty Developing Recommendation:** ACOG, AUA

First Identified: April 2017 **2019 est Medicare Utilization:** 28,865

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90912 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including emg and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient**

Global: 000 **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 15 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.90
2021 NF PE RVU: 1.43
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.90 **Referred to CPT** February 2019-EC **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90913 **Biofeedback training, perineal muscles, anorectal or urethral sphincter, including emg and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Biofeedback Training **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 15 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.50
2021 NF PE RVU: 0.40
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.50 **Referred to CPT** February 2019-EC **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

90935 **Hemodialysis procedure with single evaluation by a physician or other qualified health care professional**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,098,691

2021 Work RVU: 1.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.53

RUC Recommendation: 1.48 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90937 **Hemodialysis procedure requiring repeated evaluation(s) with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA

First Identified: February 2009

2019 est Medicare Utilization: 51,752

2021 Work RVU: 2.11
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.11

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

90945 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies), with single evaluation by a physician or other qualified health care professional**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA

First Identified: February 2009

2019 est Medicare Utilization: 165,382

2021 Work RVU: 1.56
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.83

RUC Recommendation: 1.56

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

90947 **Dialysis procedure other than hemodialysis (eg, peritoneal dialysis, hemofiltration, or other continuous renal replacement therapies) requiring repeated evaluations by a physician or other qualified health care professional, with or without substantial revision of dialysis prescription**

Global: 000 **Issue:** Hemodialysis-Dialysis Services **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 30 **Specialty Developing Recommendation:** RPA

First Identified: February 2009

2019 est Medicare Utilization: 11,769

2021 Work RVU: 2.52
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.91

RUC Recommendation: 2.52

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

Status Report: CMS Requests and Relativity Assessment Issues

90951 **End-stage renal disease (esrd) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 17

2021 Work RVU: 23.92
2021 NF PE RVU: 8.88
2021 Fac PE RVU: 8.88

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90952 **End-stage renal disease (esrd) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 4

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90953 **End-stage renal disease (esrd) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90954 **End-stage renal disease (esrd) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 571

2021 Work RVU: 15.98
2021 NF PE RVU: 5.66
2021 Fac PE RVU: 5.66

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90955 **End-stage renal disease (esrd) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 57

2021 Work RVU: 10.32
2021 NF PE RVU: 4.37
2021 Fac PE RVU: 4.37

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90956 **End-stage renal disease (esrd) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 124

2021 Work RVU: 6.64
2021 NF PE RVU: 3.10
2021 Fac PE RVU: 3.10

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90957 **End-stage renal disease (esrd) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,539

2021 Work RVU: 15.46
2021 NF PE RVU: 6.19
2021 Fac PE RVU: 6.19

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90958 **End-stage renal disease (esrd) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 393

2021 Work RVU: 9.87
2021 NF PE RVU: 4.23
2021 Fac PE RVU: 4.23

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90959 **End-stage renal disease (esrd) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 292

2021 Work RVU: 6.19
2021 NF PE RVU: 2.93
2021 Fac PE RVU: 2.93

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90960 **End-stage renal disease (esrd) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 2,218,361

2021 Work RVU: 6.77
2021 NF PE RVU: 3.20
2021 Fac PE RVU: 3.20

RUC Recommendation: RUC Recommended revised physician and clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90961 **End-stage renal disease (esrd) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 719,245

2021 Work RVU: 5.52
2021 NF PE RVU: 2.75
2021 Fac PE RVU: 2.75

RUC Recommendation: RUC Recommended revised physician and clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

90962 **End-stage renal disease (esrd) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 213,048

2021 Work RVU: 3.57
2021 NF PE RVU: 2.11
2021 Fac PE RVU: 2.11

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90963 **End-stage renal disease (esrd) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 229

2021 Work RVU: 12.09
2021 NF PE RVU: 4.93
2021 Fac PE RVU: 4.93

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90964 **End-stage renal disease (esrd) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 934

2021 Work RVU: 10.25
2021 NF PE RVU: 4.37
2021 Fac PE RVU: 4.37

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

90965 **End-stage renal disease (esrd) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 1,343

2021 Work RVU: 9.80
2021 NF PE RVU: 4.26
2021 Fac PE RVU: 4.26

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

90966 **End-stage renal disease (esrd) related services for home dialysis per full month, for patients 20 years of age and older**

Global: XXX **Issue:** End-Stage Renal Disease **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 29 **Specialty Developing Recommendation:** RPA **First Identified:** February 2009 **2019 est Medicare Utilization:** 365,733

2021 Work RVU: 5.52
2021 NF PE RVU: 2.74
2021 Fac PE RVU: 2.74

RUC Recommendation: RUC Recommended revised clinical staff time **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

91038 **Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation; prolonged (greater than 1 hour, up to 24 hours)**

Global: 000 **Issue:** Gastroenterological Tests **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 23 **Specialty Developing Recommendation:** AGA, ASGE **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,829

2021 Work RVU: 1.10
2021 NF PE RVU: 12.08
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

91110 **Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus through ileum, with interpretation and report**

Global: XXX **Issue:** Gastrointestinal Tract Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 44 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** July 2015 **2019 est Medicare Utilization:** 53,131

2021 Work RVU: 2.49
2021 NF PE RVU: 22.79
2021 Fac PE RVU: NA

RUC Recommendation: 2.49 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

91111 **Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report**

Global: XXX **Issue:** Gastrointestinal Tract Imaging **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 44 **Specialty Developing Recommendation:** ACG, AGA, ASGE **First Identified:** July 2015 **2019 est Medicare Utilization:** 146

2021 Work RVU: 1.00
2021 NF PE RVU: 26.74
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

91132 **Electrogastrography, diagnostic, transcutaneous;**

Global: XXX **Issue:** Electrogastrography **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 24 **Specialty Developing Recommendation:** AGA, ACG, ASGE **First Identified:** **2019 est Medicare Utilization:** 114

2021 Work RVU: 0.52
2021 NF PE RVU: 11.72
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

91133 **Electrogastrography, diagnostic, transcutaneous; with provocative testing**

Global: XXX **Issue:** Electrogastrography **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 24 **Specialty Developing Recommendation:** AGA, ACG, ASGE **First Identified:** **2019 est Medicare Utilization:** 14

2021 Work RVU: 0.66
2021 NF PE RVU: 12.25
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92065 **Orthoptic training**

Global: XXX **Issue:** Orthoptic Training **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 10 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 32,858

2021 Work RVU: 0.37
2021 NF PE RVU: 1.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.71 **Referred to CPT** February 2021 May 2020-Tab 37 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92081 **Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, autoplot, arc perimeter, or single stimulus level automated test, such as octopus 3 or 7 equivalent)**

Global: XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 42 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2009 **2019 est Medicare Utilization:** 92,708

2021 Work RVU: 0.30
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92082 **Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (eg, at least 2 isopters on goldmann perimeter, or semiquantitative, automated suprathreshold screening program, humphrey suprathreshold automatic diagnostic test, octopus program 33)**

Global: XXX **Issue:** Visual Field Examination **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 42 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2009 **2019 est Medicare Utilization:** 122,984

2021 Work RVU: 0.40
2021 NF PE RVU: 0.96
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92083 **Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, octopus program g-1, 32 or 42, humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)**

Global: XXX **Issue:** Visual Field Examination **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 46 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,969,637

2021 Work RVU: 0.50
2021 NF PE RVU: 1.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

920XX

Global: **Issue:** Orthoptic Training **Screen:** Harvard Valued - Utilization over 30,000-Part4 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 10 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

92100 **Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (eg, diurnal curve or medical treatment of acute elevation of intraocular pressure)**

Global: XXX **Issue:** Serial Tonometry **Screen:** Harvard Valued - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 36 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2019 est Medicare Utilization:** 31,551

2021 Work RVU: 0.61
2021 NF PE RVU: 1.85
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.61 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92133 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve**

Global: XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,814,680

2021 Work RVU: 0.40
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92134 **Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina**

Global: XXX **Issue:** Computerized Scanning Ophthalmology Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 23 **Specialty Developing Recommendation:** AAO, AOA (eye) **First Identified:** October 2008 **2019 est Medicare Utilization:** 7,509,080

2021 Work RVU: 0.45
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92135 **Deleted from CPT**

Global: **Issue:** Ophthalmic Diagnostic Imaging **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 31 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92136 **Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation**

Global: XXX **Issue:** Ophthalmic Biometry **Screen:** CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 36 **Specialty Developing Recommendation:** AAO **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,688,098

2021 Work RVU: 0.54
2021 NF PE RVU: 1.03
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92140 **Provocative tests for glaucoma, with interpretation and report, without tonography**

Global: **Issue:** Glaucoma Provacative Tests **Screen:** Harvard Valued - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 41 **Specialty Developing Recommendation:** AAO, AOA (optometry) **First Identified:** October 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92201 **Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.40
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.24

RUC Recommendation: 0.40 **Referred to CPT** February 2018 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92202 **Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.26
2021 NF PE RVU: 0.19
2021 Fac PE RVU: 0.15

RUC Recommendation: 0.26 **Referred to CPT** February 2018 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92225 **Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; initial**

Global: **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** April 2017 **2019 est Medicare Utilization:** 947,451

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92226 **Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report; subsequent**

Global: **Issue:** Ophthalmoscopy **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 05 **Specialty Developing Recommendation:** AAO, AOA (Optometry), ASRS **First Identified:** February 2018 **2019 est Medicare Utilization:** 2,551,942

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92235 **Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Harvard Valued - Utilization over 30,000 / CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** April 2011 **2019 est Medicare Utilization:** 428,183

2021 Work RVU: 0.75
2021 NF PE RVU: 2.65
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92240 **Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Codes Reported Together 75% or More-Part3 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** January 2015 **2019 est Medicare Utilization:** 10,668

2021 Work RVU: 0.80
2021 NF PE RVU: 5.07
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92242 **Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral**

Global: XXX **Issue:** Ophthalmoscopic Angiography **Screen:** Codes Reported Together 75% or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** October 2015 **2019 est Medicare Utilization:** 37,989

2021 Work RVU: 0.95
2021 NF PE RVU: 6.37
2021 Fac PE RVU: NA

RUC Recommendation: 0.95 **Referred to CPT** October 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92250 **Fundus photography with interpretation and report**

Global: XXX **Issue:** Fundus Photography **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 45 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** October 2010 **2019 est Medicare Utilization:** 3,490,129

2021 Work RVU: 0.40
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92270 **Electro-oculography with interpretation and report**

Global: XXX **Issue:** Electro-oculography **Screen:** High Volume Growth1 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,435

2021 Work RVU: 0.81
2021 NF PE RVU: 2.17
2021 Fac PE RVU: NA

RUC Recommendation: CPT Assistant article published. **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Aug 2008 and Q&A Jun 2009

92273 **Electroretinography (erg), with interpretation and report; full field (ie, fferg, flash erg, ganzfeld erg)**

Global: XXX **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 / Work Neutrality 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 68,699

2021 Work RVU: 0.69
2021 NF PE RVU: 3.11
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan. 0.80 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92274 **Electroretinography (erg), with interpretation and report; multifocal (mferg)**

Global: XXX **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 / Work Neutrality 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** September 2017 **2019 est Medicare Utilization:** 6,340

2021 Work RVU: 0.61
2021 NF PE RVU: 1.97
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan. 0.72 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92275 **Electroretinography with interpretation and report**

Global: **Issue:** Electroretinography **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 17 **Specialty Developing Recommendation:** AAO, ASRS, AOA (optometry) **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92284 **Dark adaptation examination with interpretation and report**

Global: XXX **Issue:** Dark Adaption Eye Exam **Screen:** Harvard Valued - Utilization over 30,000-Part5 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 20 **Specialty Developing Recommendation:** AAO, AOA (optometry), ASRS **First Identified:** October 2020 **2019 est Medicare Utilization:** 32,615

2021 Work RVU: 0.24
2021 NF PE RVU: 1.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.14. Review Technology **Referred to CPT** May 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92285 **External ocular photography with interpretation and report for documentation of medical progress (eg, close-up photography, slit lamp photography, goniophotography, stereo-photography)**

Global: XXX **Issue:** Ocular Photography **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 32 **Specialty Developing Recommendation:** AAO, AOA **First Identified:** October 2008 **2019 est Medicare Utilization:** 406,118

2021 Work RVU: 0.05
2021 NF PE RVU: 0.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.05 and new PE inputs **Referred to CPT** February 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92286 **Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis**

Global: XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 28 **Specialty Developing Recommendation:** AAO, AOA (optometric) **First Identified:** April 2011 **2019 est Medicare Utilization:** 115,474

2021 Work RVU: 0.40
2021 NF PE RVU: 0.72
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92287 **Anterior segment imaging with interpretation and report; with fluorescein angiography**

Global: XXX **Issue:** Anterior Segment Imaging **Screen:** Harvard Valued - Utilization over 30,000 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 21 **Specialty Developing Recommendation:** AAO, ASRS **First Identified:** **2019 est Medicare Utilization:** 7,182

2021 Work RVU: 0.81
2021 NF PE RVU: 4.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2013

Status Report: CMS Requests and Relativity Assessment Issues

92504 **Binocular microscopy (separate diagnostic procedure)**

Global: XXX **Issue:** Binocular Microscopy **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 43 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 239,518

2021 Work RVU: 0.18
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.08

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92506 **Evaluation of speech, language, voice, communication, and/or auditory processing**

Global: **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92507 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth 3 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 54 **Specialty Developing Recommendation:** ASHA **First Identified:** October 2015 **2019 est Medicare Utilization:** 350,653

2021 Work RVU: 1.30
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: 1.30 work RVU and clinical staff time removed. Remove from High Volume screen. **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92508 **Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 4,438

2021 Work RVU: 0.33
2021 NF PE RVU: 0.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92521 **Evaluation of speech fluency (eg, stuttering, cluttering)**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 197

2021 Work RVU: 2.24
2021 NF PE RVU: 1.59
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** October 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92522 **Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria);**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 3,374

2021 Work RVU: 1.92
2021 NF PE RVU: 1.26
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** October 2012 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92523 **Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language)**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 19,962

2021 Work RVU: 3.84
2021 NF PE RVU: 2.75
2021 Fac PE RVU: NA

RUC Recommendation: 3.36 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92524 **Behavioral and qualitative analysis of voice and resonance**

Global: XXX **Issue:** Speech Evaluation **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 32 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 18,441

2021 Work RVU: 1.92
2021 NF PE RVU: 1.20
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** October 2012 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92526 **Treatment of swallowing dysfunction and/or oral function for feeding**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 133,424

2021 Work RVU: 1.34
2021 NF PE RVU: 1.09
2021 Fac PE RVU: NA

RUC Recommendation: Maintain **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92537 **Caloric vestibular test with recording, bilateral; bithermal (ie, one warm and one cool irrigation in each ear for a total of four irrigations)**

Global: XXX **Issue:** Vestibular Caloric Irrigation **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** October 2014 **2019 est Medicare Utilization:** 68,931

2021 Work RVU: 0.60
2021 NF PE RVU: 0.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92538 **Caloric vestibular test with recording, bilateral; monothermal (ie, one irrigation in each ear for a total of two irrigations)**

Global: XXX **Issue:** Vestibular Caloric Irrigation **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** October 2014 **2019 est Medicare Utilization:** 6,794

2021 Work RVU: 0.30
2021 NF PE RVU: 0.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.55 **Referred to CPT** October 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92540 **Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 89,363

2021 Work RVU: 1.50
2021 NF PE RVU: 1.66
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92541 **Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 13,573

2021 Work RVU: 0.40
2021 NF PE RVU: 0.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.40 **Referred to CPT** February 2009 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

92542 **Positional nystagmus test, minimum of 4 positions, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 19,332

2021 Work RVU: 0.48
2021 NF PE RVU: 0.36
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** February 2009 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92543 **Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests), with recording**

Global: **Issue:** Vestibular Caloric Irrigation **Screen:** Codes Reported Together 95% or More / Low Value-High Volume / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2015 **Tab:** 18 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ASHA **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2014 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92544 **Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,943

2021 Work RVU: 0.27
2021 NF PE RVU: 0.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.27 **Referred to CPT** February 2009 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92545 **Oscillating tracking test, with recording**

Global: XXX **Issue:** EOG VNG **Screen:** Codes Reported Together 95% or More / CMS-Other Source – Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ASHA, AAO-HNS, AAA **First Identified:** February 2008 **2019 est Medicare Utilization:** 3,622

2021 Work RVU: 0.25
2021 NF PE RVU: 0.22
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** February 2009 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92546 **Sinusoidal vertical axis rotational testing**

Global: XXX **Issue:** EOG VNG **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:** **First Identified:** February 2014 **2019 est Medicare Utilization:** 43,026

2021 Work RVU: 0.29
2021 NF PE RVU: 3.16
2021 Fac PE RVU: NA

RUC Recommendation: Editorial change only **Referred to CPT** February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92547 **Use of vertical electrodes (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EOG VNG **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 24 **Specialty Developing Recommendation:**

First Identified: February 2014 **2019 est Medicare Utilization:** 26,526

2021 Work RVU: 0.00
2021 NF PE RVU: 0.29
2021 Fac PE RVU: NA

RUC Recommendation: Editorial change only

Referred to CPT February 2014 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

92548 **Computerized dynamic posturography sensory organization test (cdp-sot), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report;**

Global: XXX **Issue:** Computerized Dynamic Posturography **Screen:** CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 16 **Specialty Developing Recommendation:** AAA, AAN, ASHA

First Identified: February 2014 **2019 est Medicare Utilization:** 51,157

2021 Work RVU: 0.67
2021 NF PE RVU: 0.75
2021 Fac PE RVU: NA

RUC Recommendation: 0.76

Referred to CPT September 2018 / February 2014 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92549 **Computerized dynamic posturography sensory organization test (cdp-sot), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (mct) and adaptation test (adt)**

Global: XXX **Issue:** Computerized Dynamic Posturography **Screen:** CMS-Other - Utilization over 250,000 / Negative IWPUT / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 16 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.87
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: 0.96

Referred to CPT September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92550 **Tympanometry and reflex threshold measurements** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 231,898

2021 Work RVU: 0.35
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.35 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92557 **Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,255,685

2021 Work RVU: 0.60
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.60 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92558 **Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis** **Global:** XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** February 2011 **2019 est Medicare Utilization:**

2021 Work RVU: 0.17
2021 NF PE RVU: 0.10
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.17 **Referred to CPT** February 2011 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92567 **Tympanometry (impedance testing)** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More / Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 922,916

2021 Work RVU: 0.20
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.10

RUC Recommendation: 0.20 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92568 **Acoustic reflex testing, threshold** **Global:** XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,046

2021 Work RVU: 0.29
2021 NF PE RVU: 0.14
2021 Fac PE RVU: 0.13

RUC Recommendation: 0.29 work RVU and clinical staff time removed **Referred to CPT** February 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92569 **Deleted from CPT** **Global:** **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 22 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAN **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92570 **Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing**

Global: XXX **Issue:** Bundled Audiology Tests **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 21 **Specialty Developing Recommendation:** ASHA, AAO-HNS, AAA **First Identified:** **2019 est Medicare Utilization:** 38,849

2021 Work RVU: 0.55
2021 NF PE RVU: 0.38
2021 Fac PE RVU: 0.28

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92584 **Electrocochleography**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:** 11,016

2021 Work RVU: 1.00
2021 NF PE RVU: 2.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92585 **Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive**

Global: **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** October 2017 **2019 est Medicare Utilization:** 34,565

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92586 **Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited**

Global: **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:** 1,425

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92587 **Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** October 2008 **2019 est Medicare Utilization:** 58,068

2021 Work RVU: 0.35
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92588 **Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report**

Global: XXX **Issue:** Otoacoustic Emissions Measurement **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 85,077

2021 Work RVU: 0.55
2021 NF PE RVU: 0.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92597 **Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech**

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 30 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2019 est Medicare Utilization:** 2,839

2021 Work RVU: 1.26
2021 NF PE RVU: 0.77
2021 Fac PE RVU: NA

RUC Recommendation: 1.48 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92605 **Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour**

Global: XXX **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU: 1.75
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.68

RUC Recommendation: 1.75 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92606 **Therapeutic service(s) for the use of non-speech-generating device, including programming and modification**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU: 1.40
2021 NF PE RVU: 0.91
2021 Fac PE RVU: 0.54

RUC Recommendation: 1.40 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92607 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 544

2021 Work RVU: 1.85
2021 NF PE RVU: 1.75
2021 Fac PE RVU: NA

RUC Recommendation: 1.85 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92608 **Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 220

2021 Work RVU: 0.70
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92609 **Therapeutic services for the use of speech-generating device, including programming and modification**

Global: XXX **Issue:** Speech Language Pathology Services **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 28 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:** 14,910

2021 Work RVU: 1.50
2021 NF PE RVU: 1.51
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92610 **Evaluation of oral and pharyngeal swallowing function**

Global: XXX **Issue:** Speech Language Pathology Services (RUC) **Screen:** CMS Request/Speech Language Pathology Request / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 23 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 22,897

2021 Work RVU: 1.30
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.68

RUC Recommendation: Maintain **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92611 **Motion fluoroscopic evaluation of swallowing function by cine or video recording**

Global: XXX **Issue:** Speech Language Pathology Services (HCPAC) **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 39 **Specialty Developing Recommendation:** ASHA **First Identified:** NA **2019 est Medicare Utilization:** 9,673

2021 Work RVU: 1.34
2021 NF PE RVU: 1.26
2021 Fac PE RVU: NA

RUC Recommendation: 1.34 work RVU and clinical staff time removed **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92618 **Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Eval of Rx for Non-Speech Generating Device **Screen:** CMS Request/Speech Language Pathology Request **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 35 **Specialty Developing Recommendation:** ASHA **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU: 0.65
2021 NF PE RVU: 0.26
2021 Fac PE RVU: 0.25

RUC Recommendation: 0.65 **Referred to CPT** February 2011 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

92620 **Evaluation of central auditory function, with report; initial 60 minutes**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 818

2021 Work RVU: 1.50
2021 NF PE RVU: 1.15
2021 Fac PE RVU: 0.79

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92621 **Evaluation of central auditory function, with report; each additional 15 minutes (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 43

2021 Work RVU: 0.35
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.35 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92625 **Assessment of tinnitus (includes pitch, loudness matching, and masking)**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 9,371

2021 Work RVU: 1.15
2021 NF PE RVU: 0.83
2021 Fac PE RVU: 0.60

RUC Recommendation: 1.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92626 **Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 30 **Specialty Developing Recommendation:** AAA, ASHA **First Identified:** NA **2019 est Medicare Utilization:** 29,623

2021 Work RVU: 1.40
2021 NF PE RVU: 1.17
2021 Fac PE RVU: 0.74

RUC Recommendation: 1.40 **Referred to CPT** May 2018 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** July 2014

Status Report: CMS Requests and Relativity Assessment Issues

92627 **Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 30 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 7,594

2021 Work RVU: 0.33
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.33 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92640 **Diagnostic analysis with programming of auditory brainstem implant, per hour**

Global: XXX **Issue:** Audiology Services **Screen:** CMS Request - Audiology Services **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 17 **Specialty Developing Recommendation:** ASHA, AAO-HNS **First Identified:** NA **2019 est Medicare Utilization:** 11

2021 Work RVU: 1.76
2021 NF PE RVU: 1.50
2021 Fac PE RVU: 0.95

RUC Recommendation: 1.76 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92650 **Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 0.25
2021 NF PE RVU: 0.56
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** February 2019 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92651 **Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.00
2021 NF PE RVU: 1.57
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92652 **Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAO-HNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.50
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92653 **Auditory evoked potentials; neurodiagnostic, with interpretation and report**

Global: XXX **Issue:** Auditory Evoked Potentials **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 06 **Specialty Developing Recommendation:** AAA, AAN, AAO-HNS, ACNS, ASHA **First Identified:** February 2019 **2019 est Medicare Utilization:**

2021 Work RVU: 1.05
2021 NF PE RVU: 1.41
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** February 2019 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

92920 **Percutaneous transluminal coronary angioplasty; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 24,084

2021 Work RVU: 9.85
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.43

RUC Recommendation: 9.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92921 **Percutaneous transluminal coronary angioplasty; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 4.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92924 **Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,282

2021 Work RVU: 11.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.09

RUC Recommendation: 11.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92925 **Percutaneous transluminal coronary atherectomy, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 5.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92928 **Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 254,826

2021 Work RVU: 10.96
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.81

RUC Recommendation: 10.49 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92929 **Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 4.44 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92933 **Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; single major coronary artery or branch**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 19,416

2021 Work RVU: 12.29
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.27

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92934 **Percutaneous transluminal coronary atherectomy, with intracoronary stent, with coronary angioplasty when performed; each additional branch of a major coronary artery (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 5.50 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92937 **Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 18,930

2021 Work RVU: 10.95
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.80

RUC Recommendation: 10.49 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92938 **Percutaneous transluminal revascularization of or through coronary artery bypass graft (internal mammary, free arterial, venous), any combination of intracoronary stent, atherectomy and angioplasty, including distal protection when performed; each additional branch subtended by the bypass graft (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 6.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

92941 **Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 41,108

2021 Work RVU: 12.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.28

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92943 **Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; single vessel**

Global: 000 **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 9,129

2021 Work RVU: 12.31
2021 NF PE RVU: NA
2021 Fac PE RVU: 4.28

RUC Recommendation: 12.32 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92944 **Percutaneous transluminal revascularization of chronic total occlusion, coronary artery, coronary artery branch, or coronary artery bypass graft, any combination of intracoronary stent, atherectomy and angioplasty; each additional coronary artery, coronary artery branch, or bypass graft (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 6.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

92960 **Cardioversion, elective, electrical conversion of arrhythmia; external**

Global: 000 **Issue:** Cardioversion **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 201,622

2021 Work RVU: 2.00
2021 NF PE RVU: 2.49
2021 Fac PE RVU: 1.01

RUC Recommendation: 2.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92973 **Percutaneous transluminal coronary thrombectomy mechanical (list separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** RAW **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 2,130

2021 Work RVU: 3.28
2021 NF PE RVU: NA
2021 Fac PE RVU: 1.14

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

92980 **Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel** **Global:** **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

92981 **Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel (List separately in addition to code for primary procedure)** **Global:** **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92982 **Percutaneous transluminal coronary balloon angioplasty; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List / Harvard-Valued Annual Allowed Charges Greater than $10 million **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92984 **Percutaneous transluminal coronary balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92986 **Percutaneous balloon valvuloplasty; aortic valve**

Global: 090 **Issue:** Valvuloplasty **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 2,857

2021 Work RVU: 22.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 10.90

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92992 **Atrial septectomy or septostomy; transvenous method, balloon (eg, Rashkind type) (includes cardiac catheterization)**

Global: **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 76

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92993 **Atrial septectomy or septostomy; blade method (Park septostomy) (includes cardiac catheterization)**

Global: **Issue:** Atrial Septostomy **Screen:** CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 1

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

92995 **Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

92996 **Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure)**

Global: **Issue:** Percutaneous Coronary Intervention **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 10 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93000 **Electrocardiogram, routine ecg with at least 12 leads; with interpretation and report**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 20 **Specialty Developing Recommendation:** ACC **First Identified:** September 2011 **2019 est Medicare Utilization:** 11,883,535

2021 Work RVU: 0.17
2021 NF PE RVU: 0.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93005 **Electrocardiogram, routine ecg with at least 12 leads; tracing only, without interpretation and report**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** High Volume Growth1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 20 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 460,887

2021 Work RVU: 0.00
2021 NF PE RVU: 0.18
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93010 **Electrocardiogram, routine ecg with at least 12 leads; interpretation and report only**

Global: XXX **Issue:** Complete Electrocardiogram **Screen:** MPC List / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 20 **Specialty Developing Recommendation:** ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 18,866,949

2021 Work RVU: 0.17
2021 NF PE RVU: 0.06
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93012 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93014 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93015 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress Tests **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 999,644

2021 Work RVU: 0.75
2021 NF PE RVU: 1.26
2021 Fac PE RVU: NA

RUC Recommendation: 0.75. CPT Assistant published. **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

93016 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress Tests **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,047,732

2021 Work RVU: 0.45
2021 NF PE RVU: 0.16
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93017 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; tracing only, without interpretation and report**

Global: XXX **Issue:** Cardiovascular Stress Tests **Screen:** High Volume Growth1 / CMS Request - Practice Expense Review / Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 96,453

2021 Work RVU: 0.00
2021 NF PE RVU: 0.99
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93018 **Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; interpretation and report only**

Global: XXX **Issue:** Cardiovascular Stress Tests and Echocardiography **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 47 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,241,516

2021 Work RVU: 0.30
2021 NF PE RVU: 0.11
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.30 **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

93025 **Microvolt t-wave alternans for assessment of ventricular arrhythmias**

Global: XXX **Issue:** Microvolt T-Wave Assessment **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 18 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:** 213

2021 Work RVU: 0.75
2021 NF PE RVU: 3.15
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93040 **Rhythm ecg, 1-3 leads; with interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 34 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 108,714

2021 Work RVU: 0.15
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93041 **Rhythm ecg, 1-3 leads; tracing only without interpretation and report**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 34 **Specialty Developing Recommendation:** ACC

First Identified: February 2009 **2019 est Medicare Utilization:** 12,914

2021 Work RVU: 0.00
2021 NF PE RVU: 0.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 (PE only)

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

93042 **Rhythm ecg, 1-3 leads; interpretation and report only**

Global: XXX **Issue:** Rhythm EKG **Screen:** Havard Valued - Utilization over 1 Million **Complete?** Yes

Most Recent RUC Meeting: October 2009 **Tab:** 34 **Specialty Developing Recommendation:** ACC, ACEP

First Identified: October 2008 **2019 est Medicare Utilization:** 362,235

2021 Work RVU: 0.15
2021 NF PE RVU: 0.04
2021 Fac PE RVU: 0.04

RUC Recommendation: 0.15

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

93224 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC

First Identified: October 2009 **2019 est Medicare Utilization:** 284,557

2021 Work RVU: 0.39
2021 NF PE RVU: 1.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.52

Referred to CPT February 2010
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

93225 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; recording (includes connection, recording, and disconnection)**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 110,328

2021 Work RVU: 0.00
2021 NF PE RVU: 0.57
2021 Fac PE RVU: NA

RUC Recommendation: N/A no physician work **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93226 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; scanning analysis with report**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 154,751

2021 Work RVU: 0.00
2021 NF PE RVU: 1.18
2021 Fac PE RVU: NA

RUC Recommendation: N/A no physician work **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93227 **External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 344,162

2021 Work RVU: 0.39
2021 NF PE RVU: 0.14
2021 Fac PE RVU: 0.14

RUC Recommendation: 0.52 **Referred to CPT** Feburary 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93228 **External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ecg data storage (retrievable with query) with ecg triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 20 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2009 **2019 est Medicare Utilization:** 186,123

2021 Work RVU: 0.52
2021 NF PE RVU: 0.19
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93229 **External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ecg data storage (retrievable with query) with ecg triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; technical support for connection and patient instructions for use, attended surveillance, analysis and transmission of daily and emergent data reports as prescribed by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: October 2020 **Tab:** 20 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2009 **2019 est Medicare Utilization:** 271,792

2021 Work RVU: 0.00
2021 NF PE RVU: 20.46
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93230 **Deleted from CPT**

Global: **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93231 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:**

First Identified: October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93232 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:**

First Identified: October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93233 **Deleted from CPT**

Global: **Issue:** Cardiac Device Monitoring **Screen:** CMS Request - 2009 Final Rule, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC

First Identified: NA **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93235 **Deleted from CPT**

Global: **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:**

First Identified: October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93236 **Deleted from CPT**

Global: **Issue:** Cardiovascular Stress Test **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACC

First Identified: February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93237 **Deleted from CPT**

Global: **Issue:** Wearable Cardiac Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2010 **Tab:** 31 **Specialty Developing Recommendation:** ACC

First Identified: October 2009 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93268 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 11,689

2021 Work RVU: 0.52
2021 NF PE RVU: 5.22
2021 Fac PE RVU: NA

RUC Recommendation: 0.52 **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93270 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 39,075

2021 Work RVU: 0.00
2021 NF PE RVU: 0.25
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** February 2010 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93271 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; transmission and analysis**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 54,627

2021 Work RVU: 0.00
2021 NF PE RVU: 4.79
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** February 2010 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93272 **External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** External Cardiovascular Device Monitoring **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 25 **Specialty Developing Recommendation:** ACC **First Identified:** October 2009 **2019 est Medicare Utilization:** 104,829

2021 Work RVU: 0.52
2021 NF PE RVU: 0.18
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.52 **Referred to CPT** February 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93279 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 152,741

2021 Work RVU: 0.65
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: 0.65 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93280 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 986,249

2021 Work RVU: 0.77
2021 NF PE RVU: 1.47
2021 Fac PE RVU: NA

RUC Recommendation: 0.77 **Referred to CPT** February 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93281 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 73,701

2021 Work RVU: 0.85
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93282 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 115,690

2021 Work RVU: 0.85
2021 NF PE RVU: 1.42
2021 Fac PE RVU: NA

RUC Recommendation: 0.85 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93283 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 214,401

2021 Work RVU: 1.15
2021 NF PE RVU: 1.64
2021 Fac PE RVU: NA

RUC Recommendation: 1.15 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93284 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 246,603

2021 Work RVU: 1.25
2021 NF PE RVU: 1.77
2021 Fac PE RVU: NA

RUC Recommendation: 1.25 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93285 **Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 40,620

2021 Work RVU: 0.52
2021 NF PE RVU: 1.18
2021 Fac PE RVU: NA

RUC Recommendation: 0.52 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93286 **Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 20,480

2021 Work RVU: 0.30
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.30 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93287 **Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 12,854

2021 Work RVU: 0.45
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93288 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 242,876

2021 Work RVU: 0.43
2021 NF PE RVU: 1.15
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93289 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 97,500

2021 Work RVU: 0.75
2021 NF PE RVU: 1.29
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93290 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 118,819

2021 Work RVU: 0.43
2021 NF PE RVU: 1.07
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93291 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 68,111

2021 Work RVU: 0.37
2021 NF PE RVU: 1.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93292 **Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,142

2021 Work RVU: 0.43
2021 NF PE RVU: 0.98
2021 Fac PE RVU: NA

RUC Recommendation: 0.43 **Referred to CPT** February 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93293 **Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 50,828

2021 Work RVU: 0.31
2021 NF PE RVU: 1.15
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93294 **Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,162,316

2021 Work RVU: 0.60
2021 NF PE RVU: 0.24
2021 Fac PE RVU: 0.24

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93295 **Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 618,312

2021 Work RVU: 0.74
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.74 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93296 **Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 25 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,298,857

2021 Work RVU: 0.00
2021 NF PE RVU: 0.73
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs and Refer to CPT **Referred to CPT** February 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93297 **Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 436,176

2021 Work RVU: 0.52
2021 NF PE RVU: 0.21
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93298 **Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional**

Global: XXX **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 23 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 718,193

2021 Work RVU: 0.52
2021 NF PE RVU: 0.21
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.52 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93299 **Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results**

Global: **Issue:** Cardiac Electrophysiology Device Monitoring Services **Screen:** CMS High Expenditure Procedural Codes2 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** July 2015 **2019 est Medicare Utilization:** 790,455

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93306 **Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, complete, with spectral doppler echocardiography, and with color flow doppler echocardiography**

Global: XXX **Issue:** Complete Transthoracic Echocardiography (TTE) with Doppler **Screen:** CMS High Expenditure Procedural Codes2 / CMS Request - Final Rule for 2019 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 21 **Specialty Developing Recommendation:** ACC, ASE **First Identified:** July 2015 **2019 est Medicare Utilization:** 7,396,555

2021 Work RVU: 1.46
2021 NF PE RVU: 4.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.46 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93307 **Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, complete, without spectral or color doppler echocardiography**

Global: XXX **Issue:** Transthoracic Echocardiography (TTE) **Screen:** CMS Request - Practice Expense Review / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 42 **Specialty Developing Recommendation:** ACC **First Identified:** NA **2019 est Medicare Utilization:** 26,672

2021 Work RVU: 0.92
2021 NF PE RVU: 3.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.92 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93308 **Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, follow-up or limited study**

Global: XXX **Issue:** Transthoracic Echocardiography (TTE) **Screen:** CMS Fastest Growing, Harvard Valued - Utilization over 100,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 42 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:** 435,885

2021 Work RVU: 0.53
2021 NF PE RVU: 2.39
2021 Fac PE RVU: NA

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93320 **Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (list separately in addition to codes for echocardiographic imaging); complete**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 30 **Specialty Developing Recommendation:** ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 365,942

2021 Work RVU: 0.38
2021 NF PE RVU: 1.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.38 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93321 **Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (list separately in addition to codes for echocardiographic imaging); follow-up or limited study (list separately in addition to codes for echocardiographic imaging)**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 30 **Specialty Developing Recommendation:** ACC **First Identified:** October 2013 **2019 est Medicare Utilization:** 239,405

2021 Work RVU: 0.15
2021 NF PE RVU: 0.62
2021 Fac PE RVU: NA

RUC Recommendation: 0.15 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93325 **Doppler echocardiography color flow velocity mapping (list separately in addition to codes for echocardiography)**

Global: ZZZ **Issue:** Doppler Echocardiography **Screen:** CMS Request - Practice Expense Review / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 30 **Specialty Developing Recommendation:** ACC

First Identified: February 2009

2019 est Medicare Utilization: 606,488

2021 Work RVU: 0.07
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.07

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93350 **Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report;**

Global: XXX **Issue:** Stress Transthoracic Echocardiography (TTE) Complete **Screen:** Other - Identified by RUC / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 26 **Specialty Developing Recommendation:** ACC, ASE

First Identified: April 2008

2019 est Medicare Utilization: 95,788

2021 Work RVU: 1.46
2021 NF PE RVU: 4.11
2021 Fac PE RVU: NA

RUC Recommendation: 1.46; CPT Assistant article published

Referred to CPT October 2010

Result: Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2010

93351 **Echocardiography, transthoracic, real-time with image documentation (2d), includes m-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional**

Global: XXX **Issue:** Stress Transthoracic Echocardiography (TTE) Complete **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 26 **Specialty Developing Recommendation:** ACC, ASE

First Identified: July 2015

2019 est Medicare Utilization: 241,940

2021 Work RVU: 1.75
2021 NF PE RVU: 5.13
2021 Fac PE RVU: NA

RUC Recommendation: 1.75

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93451 **Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 44,232

2021 Work RVU: 2.47
2021 NF PE RVU: 23.82
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Modifier -51 exempt list. 3.02 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93452 **Left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 3,594

2021 Work RVU: 4.50
2021 NF PE RVU: 22.80
2021 Fac PE RVU: NA

RUC Recommendation: 4.32 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93453 **Combined right and left heart catheterization including intraprocedural injection(s) for left ventriculography, imaging supervision and interpretation, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 2,368

2021 Work RVU: 5.99
2021 NF PE RVU: 28.76
2021 Fac PE RVU: NA

RUC Recommendation: 5.98 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93454 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation;**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 127,375

2021 Work RVU: 4.54
2021 NF PE RVU: 22.77
2021 Fac PE RVU: NA

RUC Recommendation: 4.95 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93455 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 27,649

2021 Work RVU: 5.29
2021 NF PE RVU: 25.34
2021 Fac PE RVU: NA

RUC Recommendation: 6.15 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93456 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right heart catheterization**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 19,829

2021 Work RVU: 5.90
2021 NF PE RVU: 28.29
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Modifier -51 Exempt List. 6.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93457 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) including intraprocedural injection(s) for bypass graft angiography and right heart catheterization**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 3,711

2021 Work RVU: 6.64
2021 NF PE RVU: 30.82
2021 Fac PE RVU: NA

RUC Recommendation: 7.66 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93458 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 507,961

2021 Work RVU: 5.60
2021 NF PE RVU: 25.90
2021 Fac PE RVU: NA

RUC Recommendation: 6.51 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93459 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 90,436

2021 Work RVU: 6.35
2021 NF PE RVU: 27.63
2021 Fac PE RVU: NA

RUC Recommendation: 7.34 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93460 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 89,701

2021 Work RVU: 7.10
2021 NF PE RVU: 30.59
2021 Fac PE RVU: NA

RUC Recommendation: 7.88 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93461 **Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed, catheter placement(s) in bypass graft(s) (internal mammary, free arterial, venous grafts) with bypass graft angiography**

Global: 000 **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 14,051

2021 Work RVU: 7.85
2021 NF PE RVU: 33.97
2021 Fac PE RVU: NA

RUC Recommendation: 9.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93462 **Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6,479

2021 Work RVU: 3.73
2021 NF PE RVU: 1.60
2021 Fac PE RVU: 1.60

RUC Recommendation: 3.73 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93463 **Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6,287

2021 Work RVU: 2.00
2021 NF PE RVU: 0.70
2021 Fac PE RVU: 0.70

RUC Recommendation: 2.00 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93464 **Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 1,054

2021 Work RVU: 1.80
2021 NF PE RVU: 5.08
2021 Fac PE RVU: NA

RUC Recommendation: 1.80 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93501 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93503 **Insertion and placement of flow directed catheter (eg, swan-ganz) for monitoring purposes**

Global: 000 **Issue:** Insertion of Catheter **Screen:** CMS High Expenditure Procedural Codes2 / Codes Reported Together 75%or More-Part4 / Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** ACR, ASA **First Identified:** July 2015 **2019 est Medicare Utilization:** 71,386

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.38

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93508 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93510 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More/ CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93511 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93514 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93524 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93526 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93527 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93528 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93529 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93539 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93540 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93541 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93542 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93543 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review, Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93544 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93545 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93555 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93556 **Deleted from CPT**

Global: **Issue:** Cardiac Catheterization **Screen:** Codes Reported Together 95% or More / CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 31 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2009 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93561 **Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)**

Global: ZZZ **Issue:** Cardiac Output Measurement **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 27 **Specialty Developing Recommendation:**

First Identified: October 2017 **2019 est Medicare Utilization:** 6

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 0.77

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

93562 **Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output**

Global: ZZZ **Issue:** Cardiac Output Measurement **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 27 **Specialty Developing Recommendation:**

First Identified: October 2017 **2019 est Medicare Utilization:** 14

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 0.95

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

93563 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC

First Identified: **2019 est Medicare Utilization:** 167

2021 Work RVU: 1.11
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.39

RUC Recommendation: 2.00

Referred to CPT October 2009
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

93564 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Pulmonary Angiography **Screen:** Survey Below 30 Threshold **Complete?** No

Most Recent RUC Meeting: October 2021 **Tab:** 08 **Specialty Developing Recommendation:** ACC, SCAI **First Identified:** October 2021 **2019 est Medicare Utilization:** 6

2021 Work RVU: 1.13
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.39

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

93564 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 6

2021 Work RVU: 1.13
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.39

RUC Recommendation: 2.10 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93565 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 80

2021 Work RVU: 0.86
2021 NF PE RVU: 0.30
2021 Fac PE RVU: 0.30

RUC Recommendation: 1.90 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93566 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 388

2021 Work RVU: 0.86
2021 NF PE RVU: 3.14
2021 Fac PE RVU: 0.30

RUC Recommendation: 0.96 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93567 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 28,640

2021 Work RVU: 0.97
2021 NF PE RVU: 2.33
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.97 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93568 **Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Diagnostic Cardiac Catheterization **Screen:** Codes Reported Together 95% or More **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 28 **Specialty Developing Recommendation:** ACC **First Identified:** **2019 est Medicare Utilization:** 1,334

2021 Work RVU: 0.88
2021 NF PE RVU: 2.81
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.98 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93571 **Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Coronary Flow Reserve Measurement **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 13 **Specialty Developing Recommendation:** ACC, SCAI **First Identified:** October 2016 **2019 est Medicare Utilization:** 69,945

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93572 **Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Coronary Flow Reserve Measurement **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 13 **Specialty Developing Recommendation:** ACC, SCAI **First Identified:** October 2017 **2019 est Medicare Utilization:** 12,600

2021 Work RVU: 0.00
2021 NF PE RVU: NA
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93613 **Intracardiac electrophysiologic 3-dimensional mapping (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** CMS Fastest Growing / High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2008 **2019 est Medicare Utilization:** 80,773

2021 Work RVU: 5.23
2021 NF PE RVU: NA
2021 Fac PE RVU: 2.27

RUC Recommendation: 5.23 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93620 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with right atrial pacing and recording, right ventricular pacing and recording, his bundle recording**

Global: 000 **Issue:** Intracardiac Catheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 8,849

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 11.57 **Referred to CPT** October 2011 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93621 **Comprehensive electrophysiologic evaluation including insertion and repositioning of multiple electrode catheters with induction or attempted induction of arrhythmia; with left atrial pacing and recording from coronary sinus or left atrium (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2019 **2019 est Medicare Utilization:** 29,892

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93623 **Programmed stimulation and pacing after intravenous drug infusion (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Pacing Heart Stimulation **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 22 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2018 **2019 est Medicare Utilization:** 38,626

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Referral to CPT for parenthetical. 2.04 **Referred to CPT** May 2019 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93641 **Electrophysiologic evaluation of single or dual chamber pacing cardioverter-defibrillator leads including defibrillation threshold evaluation (induction of arrhythmia, evaluation of sensing and pacing for arrhythmia termination) at time of initial implantation or replacement; with testing of single or dual chamber pacing cardioverter-defibrillator pulse generator**

Global: 000 **Issue:** Insertion/Removal of Pacemaker or Pacing Carioverter-Defibillator **Screen:** Codes Reported Together 75% or More-Part1 / Pre-Time Analysis **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 21 **Specialty Developing Recommendation:** ACC **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,210

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Maintain work RVU and adjust the times from pre-time package 2B.

Referred to CPT February 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93651 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathways, accessory atrioventricular connections or other atrial foci, singly or in combination**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93652 **Intracardiac catheter ablation of arrhythmogenic focus; for treatment of ventricular tachycardia**

Global: **Issue:** Bundling EPS with Transcatheter Ablation **Screen:** CMS Fastest Growing/Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 11 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT October 2011 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93653 **Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and his bundle recording, when performed; with treatment of supraventricular tachycardia by ablation of fast or slow atrioventricular pathway, accessory atrioventricular connection, cavo-tricuspid isthmus or other single atrial focus or source of atrial re-entry**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 31,821

2021 Work RVU: 14.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 6.40

RUC Recommendation: 15.00 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93654 **Comprehensive electrophysiologic evaluation with insertion and repositioning of multiple electrode catheters, induction or attempted induction of an arrhythmia with right atrial pacing and recording and catheter ablation of arrhythmogenic focus, including intracardiac electrophysiologic 3-dimensional mapping, right ventricular pacing and recording, left atrial pacing and recording from coronary sinus or left atrium, and his bundle recording, when performed; with treatment of ventricular tachycardia or focus of ventricular ectopy including left ventricular pacing and recording, when performed**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 7,750

2021 Work RVU: 19.75
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.55

RUC Recommendation: 18.10 **Referred to CPT** October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93655 **Intracardiac catheter ablation of a discrete mechanism of arrhythmia which is distinct from the primary ablated mechanism, including repeat diagnostic maneuvers, to treat a spontaneous or induced arrhythmia (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 /High Volume Growth7 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 31,147

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.27

RUC Recommendation: 7.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93656 **Comprehensive electrophysiologic evaluation including transseptal catheterizations, insertion and repositioning of multiple electrode catheters with intracardiac catheter ablation of atrial fibrillation by pulmonary vein isolation, including intracardiac electrophysiologic 3-dimensional mapping, intracardiac echocardiography including imaging supervision and interpretation, induction or attempted induction of an arrhythmia including left or right atrial pacing/recording, right ventricular pacing/recording, and his bundle recording, when performed**

Global: 000 **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 53,327

2021 Work RVU: 19.77
2021 NF PE RVU: NA
2021 Fac PE RVU: 8.63

RUC Recommendation: 17.00 **Referred to CPT** October 2020 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

93657 **Additional linear or focal intracardiac catheter ablation of the left or right atrium for treatment of atrial fibrillation remaining after completion of pulmonary vein isolation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS **First Identified:** October 2011 **2019 est Medicare Utilization:** 21,959

2021 Work RVU: 7.50
2021 NF PE RVU: NA
2021 Fac PE RVU: 3.26

RUC Recommendation: 7.00 **Referred to CPT** October 2011 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93662 **Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Cardiac Ablation Services Bundling **Screen:** High Volume Growth1 / High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 07 **Specialty Developing Recommendation:** ACC, HRS

First Identified: February 2008

2019 est Medicare Utilization: 63,470

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: 2.53

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

93668 **Peripheral arterial disease (pad) rehabilitation, per session**

Global: XXX **Issue:** Peripheral Artery Disease (PAD) Rehabilitation (PE Only) **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 28 **Specialty Developing Recommendation:**

First Identified: July 2017

2019 est Medicare Utilization: 814

2021 Work RVU: 0.00
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: PE Only

93701 **Bioimpedance-derived physiologic cardiovascular analysis**

Global: XXX **Issue:** **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: October 2010

2019 est Medicare Utilization: 14,268

2021 Work RVU: 0.00
2021 NF PE RVU: 0.80
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

93731 **Deleted from CPT**

Global: **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC

First Identified: October 2008

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

93732 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93733 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93743 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

93744 **Deleted from CPT** **Global:** **Issue:** Cardiology Services **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2008 **Tab:** 26 **Specialty Developing Recommendation:** ACC **First Identified:** October 2008 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93750 **Interrogation of ventricular assist device (vad), in person, with physician or other qualified health care professional analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report**

Global: XXX **Issue:** Ventricular Assist Device (VAD) Interrogation **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 24 **Specialty Developing Recommendation:** AATS, ACC, STS **First Identified:** October 2018 **2019 est Medicare Utilization:** 97,423

2021 Work RVU: 0.75
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.29

RUC Recommendation: 0.85 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93792 **Patient/caregiver training for initiation of home international normalized ratio (inr) monitoring under the direction of a physician or other qualified health care professional, face-to-face, including use and care of the inr monitor, obtaining blood sample, instructions for reporting home inr test results, and documentation of patient's/caregiver's ability to perform testing and report results**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:** 1,742

2021 Work RVU: 0.00
2021 NF PE RVU: 1.90
2021 Fac PE RVU: NA

RUC Recommendation: Review in 2 years. 0.00 PE Only **Referred to CPT** September 2016 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

93793 **Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (inr) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:** 1,555,390

2021 Work RVU: 0.18
2021 NF PE RVU: 0.14
2021 Fac PE RVU: NA

RUC Recommendation: Review in 2 years. 0.18 **Referred to CPT** September 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93875 **Deleted from CPT**

Global: **Issue:** Noninvasive Vascular Diagnostic Studies **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** SS in process of developing draft of CPT Asst article (Aug 2011). Code was deleted

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93880 **Duplex scan of extracranial arteries; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR, ACC, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,198,611

2021 Work RVU: 0.80
2021 NF PE RVU: 4.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☑ **Published in CPT Asst:** Addressed in CPT Coding Changes

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93882 **Duplex scan of extracranial arteries; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS High Expenditure Procedural Codes1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** January 2012 **2019 est Medicare Utilization:** 33,564

2021 Work RVU: 0.50
2021 NF PE RVU: 3.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93886 **Transcranial doppler study of the intracranial arteries; complete study** **Global:** XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 104,495

2021 Work RVU: 0.91
2021 NF PE RVU: 7.16
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** October 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93888 **Transcranial doppler study of the intracranial arteries; limited study** **Global:** XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 10,532

2021 Work RVU: 0.50
2021 NF PE RVU: 4.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** October 2010 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93890 **Transcranial doppler study of the intracranial arteries; vasoreactivity study** **Global:** XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2019 **2019 est Medicare Utilization:** 52,137

2021 Work RVU: 1.00
2021 NF PE RVU: 7.28
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93892 **Transcranial doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection**

Global: XXX **Issue:** **Screen:** High Volume Growth6 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:**

First Identified: October 2019

2019 est Medicare Utilization: 55,222

2021 Work RVU: 1.15
2021 NF PE RVU: 8.14
2021 Fac PE RVU: NA

RUC Recommendation: Remove from Screen

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

93895 **Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral**

Global: XXX **Issue:** Carotid Intima-Media Thickness Ultrasound **Screen:** New Code in CPT 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 37 **Specialty Developing Recommendation:** No Interest

First Identified: April 2014

2019 est Medicare Utilization:

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Rescind April 2014 recommendation, contractor price.

Referred to CPT

Result: Not Part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

93922 **Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC

First Identified: October 2008

2019 est Medicare Utilization: 694,382

2021 Work RVU: 0.25
2021 NF PE RVU: 2.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.25

Referred to CPT February 2010

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93923 **Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 440,595

2021 Work RVU: 0.45
2021 NF PE RVU: 3.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93924 **Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study**

Global: XXX **Issue:** Extremity Non-Invasive Arterial Physiologic Studies **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 27 **Specialty Developing Recommendation:** SVS, ACR, ACC **First Identified:** February 2009 **2019 est Medicare Utilization:** 61,266

2021 Work RVU: 0.50
2021 NF PE RVU: 4.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** February 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93925 **Duplex scan of lower extremity arteries or arterial bypass grafts; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 661,535

2021 Work RVU: 0.80
2021 NF PE RVU: 6.56
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

93926 **Duplex scan of lower extremity arteries or arterial bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 262,918

2021 Work RVU: 0.50
2021 NF PE RVU: 3.82
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

93930 **Duplex scan of upper extremity arteries or arterial bypass grafts; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** November 2013 **2019 est Medicare Utilization:** 23,417

2021 Work RVU: 0.80
2021 NF PE RVU: 5.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93931 **Duplex scan of upper extremity arteries or arterial bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** AAN, ACC, ACR, SIR, SVS **First Identified:** February 2010 **2019 est Medicare Utilization:** 47,500

2021 Work RVU: 0.50
2021 NF PE RVU: 3.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** October 2010 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93965 **Noninvasive physiologic studies of extremity veins, complete bilateral study (eg, Doppler waveform analysis with responses to compression and other maneuvers, phleborheography, impedance plethysmography)**

Global: **Issue:** Non-invasive Physiologic Studies of Extremity Veins **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 47 **Specialty Developing Recommendation:** ACC, ACR, SCAI, SVS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

93970 **Duplex scan of extremity veins including responses to compression and other maneuvers; complete bilateral study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 500,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACC, ACR, SVS **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,626,806

2021 Work RVU: 0.70
2021 NF PE RVU: 4.97
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93971 **Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** Low Value-High Volume / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR, SVS, ACC **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,753,619

2021 Work RVU: 0.45
2021 NF PE RVU: 3.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

93975 **Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; complete study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR, SVS, ACC **First Identified:** November 2013 **2019 est Medicare Utilization:** 218,302

2021 Work RVU: 1.16
2021 NF PE RVU: 6.85
2021 Fac PE RVU: NA

RUC Recommendation: 1.30 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

93976 **Duplex scan of arterial inflow and venous outflow of abdominal, pelvic, scrotal contents and/or retroperitoneal organs; limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS Fastest Growing / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACR **First Identified:** October 2008 **2019 est Medicare Utilization:** 173,269

2021 Work RVU: 0.80
2021 NF PE RVU: 3.95
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93978 **Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 250,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** **First Identified:** April 2013 **2019 est Medicare Utilization:** 287,616

2021 Work RVU: 0.80
2021 NF PE RVU: 4.61
2021 Fac PE RVU: NA

RUC Recommendation: 0.97 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93979 **Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; unilateral or limited study**

Global: XXX **Issue:** Duplex Scans **Screen:** CMS-Other - Utilization over 250,000 / CMS Request - Final Rule for 2014 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 33 **Specialty Developing Recommendation:** **First Identified:** October 2013 **2019 est Medicare Utilization:** 66,512

2021 Work RVU: 0.50
2021 NF PE RVU: 3.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93982 **Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report**

Global: **Issue:** Endovascular Repair Procedures (EVAR) **Screen:** Codes Reported Together 75%or More-Part3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 10 **Specialty Developing Recommendation:** SVS, SIR, STS, AATS **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

93985 **Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study**

Global: XXX **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.80
2021 NF PE RVU: 6.89
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93986 **Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete unilateral study**

Global: XXX **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: October 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.50
2021 NF PE RVU: 3.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

93990 **Duplex scan of hemodialysis access (including arterial inflow, body of access and venous outflow)**

Global: XXX **Issue:** Doppler Flow Testing **Screen:** CMS Fastest Growing / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2014 **Tab:** 40 **Specialty Developing Recommendation:** ACR, SVS

First Identified: October 2008 **2019 est Medicare Utilization:** 132,133

2021 Work RVU: 0.50
2021 NF PE RVU: 3.90
2021 Fac PE RVU: NA

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94010 **Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation**

Global: XXX **Issue:** Spirometry **Screen:** Low Value-High Volume **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 12 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,234,541

2021 Work RVU: 0.17
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

94014 **Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and review and interpretation by a physician or other qualified health care professional**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 47

2021 Work RVU: 0.52
2021 NF PE RVU: 1.07
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94015 **Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 38

2021 Work RVU: 0.00
2021 NF PE RVU: 0.89
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94016 **Patient-initiated spirometric recording per 30-day period of time; review and interpretation only by a physician or other qualified health care professional**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** April 2008 **2019 est Medicare Utilization:** 5,244

2021 Work RVU: 0.52
2021 NF PE RVU: 0.18
2021 Fac PE RVU: 0.18

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94060 **Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration**

Global: XXX **Issue:** Spirometry **Screen:** MPC List / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 12 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,160,195

2021 Work RVU: 0.22
2021 NF PE RVU: 1.11
2021 Fac PE RVU: NA

RUC Recommendation: 0.22

Referred to CPT

Result: Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94200 **Maximum breathing capacity, maximal voluntary ventilation**

Global: XXX **Issue:** Lung Function Test **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 28 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** October 2017 **2019 est Medicare Utilization:** 74,436

2021 Work RVU: 0.05
2021 NF PE RVU: 0.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.05

Referred to CPT

Result: Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94240 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94250 **Expired gas collection, quantitative, single procedure (separate procedure)**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 20,825

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94260 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 / **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94350 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94360 **Deleted from CPT**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94370 **Determination of airway closing volume, single breath tests**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94400 **Breathing response to CO2 (CO2 response curve)**

Global: **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** **2019 est Medicare Utilization:** 1,310

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94450 **Breathing response to hypoxia (hypoxia response curve)**

Global: XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 56

2021 Work RVU: 0.40
2021 NF PE RVU: 1.35
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

94617 **Exercise test for bronchospasm, including pre- and post-spirometry and pulse oximetry; with electrocardiographic recording(s)**

Global: XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2016 **2019 est Medicare Utilization:** 9,892

2021 Work RVU: 0.70
2021 NF PE RVU: 1.98
2021 Fac PE RVU: NA

RUC Recommendation: 0.70 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94618 **Pulmonary stress testing (eg, 6-minute walk test), including measurement of heart rate, oximetry, and oxygen titration, when performed**

Global: XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2016 **2019 est Medicare Utilization:** 271,019

2021 Work RVU: 0.48
2021 NF PE RVU: 0.46
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** February 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94620 **Pulmonary stress testing; simple (eg, 6-minute walk test, prolonged exercise test for bronchospasm with pre- and post-spirometry and oximetry)**

Global: **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94621 **Cardiopulmonary exercise testing, including measurements of minute ventilation, co2 production, o2 uptake, and electrocardiographic recordings**

Global: XXX **Issue:** Pulmonary Diagnostic Tests **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 05 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** January 2016 **2019 est Medicare Utilization:** 21,378

2021 Work RVU: 1.42
2021 NF PE RVU: 3.07
2021 Fac PE RVU: NA

RUC Recommendation: 1.42 **Referred to CPT** February 2016 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94640 **Pressurized or nonpressurized inhalation treatment for acute airway obstruction for therapeutic purposes and/or for diagnostic purposes such as sputum induction with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (ippb) device**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 /CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** AAFP, ATS, CHEST, **First Identified:** **2019 est Medicare Utilization:** 601,038

2021 Work RVU: 0.00
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

94667 **Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; initial demonstration and/or evaluation**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2019 **2019 est Medicare Utilization:** 6,331

2021 Work RVU: 0.00
2021 NF PE RVU: 0.61
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

94668 **Manipulation chest wall, such as cupping, percussing, and vibration to facilitate lung function; subsequent**

Global: XXX **Issue:** Evaluation of Wheezing **Screen:** Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** AAFP, ATS, CHEST, **First Identified:** **2019 est Medicare Utilization:** 5,171

2021 Work RVU: 0.00
2021 NF PE RVU: 0.94
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs CPT Assistant article published **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

Status Report: CMS Requests and Relativity Assessment Issues

94669 **Mechanical chest wall oscillation to facilitate lung function, per session** **Global:** XXX **Issue:** Evaluation of Wheezing **Screen:** CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** April 2019 **2019 est Medicare Utilization:** 324

2021 Work RVU: 0.00
2021 NF PE RVU: 0.65
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94681 **Oxygen uptake, expired gas analysis; including co2 output, percentage oxygen extracted** **Global:** XXX **Issue:** Pulmonary Tests **Screen:** High Volume Growth1 / CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** AACE, TES, ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 7,816

2021 Work RVU: 0.20
2021 NF PE RVU: 1.27
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

94720 **Carbon monoxide diffusing capacity (eg, single breath, steady state)** **Global:** **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94725 **Membrane diffusion capacity**

Global: **Issue:** Pulmonary Tests **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 45 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2010 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

94726 **Plethysmography for determination of lung volumes and, when performed, airway resistance**

Global: XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 681,512

2021 Work RVU: 0.26
2021 NF PE RVU: 1.30
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94727 **Gas dilution or washout for determination of lung volumes and, when performed, distribution of ventilation and closing volumes**

Global: XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 348,523

2021 Work RVU: 0.26
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94728 **Airway resistance by oscillometry** **Global:** XXX **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 4,985

2021 Work RVU: 0.26
2021 NF PE RVU: 0.91
2021 Fac PE RVU: NA

RUC Recommendation: 0.31 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94729 **Diffusing capacity (eg, carbon monoxide, membrane) (list separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** Pulmonary Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 19 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,113,315

2021 Work RVU: 0.19
2021 NF PE RVU: 1.52
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** February 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

94750 **Pulmonary compliance study (eg, plethysmography, volume and pressure measurements)** **Global:** **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** January 2019 **2019 est Medicare Utilization:** 18,981

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94760 **Noninvasive ear or pulse oximetry for oxygen saturation; single determination** **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2019 est Medicare Utilization:** 29,834

2021 Work RVU: 0.00
2021 NF PE RVU: 0.06
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94761 **Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (eg, during exercise)** **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** NA **2019 est Medicare Utilization:** 16,501

2021 Work RVU: 0.00
2021 NF PE RVU: 0.10
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

94762 **Noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure)** **Global:** XXX **Issue:** Measure Blood Oxygen Level **Screen:** CMS Fastest Growing, CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 32 **Specialty Developing Recommendation:** ACCP, ATS **First Identified:** October 2008 **2019 est Medicare Utilization:** 208,171

2021 Work RVU: 0.00
2021 NF PE RVU: 0.78
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

94770 **Carbon dioxide, expired gas determination by infrared analyzer**

Global: **Issue:** Evaluation of Wheezing **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 25 **Specialty Developing Recommendation:** ATS, CHEST **First Identified:** February 2008 **2019 est Medicare Utilization:** 5,724

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2019 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Mar 2014

95004 **Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 27 **Specialty Developing Recommendation:** AAAAI, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 10,738,966

2021 Work RVU: 0.01
2021 NF PE RVU: 0.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.01 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95010 **Percutaneous tests (scratch, puncture, prick) sequential and incremental, with drugs, biologicals or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests**

Global: **Issue:** Percutaneous Allergy Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95012 **Nitric oxide expired gas determination** **Global:** XXX **Issue:** Exhaled Nitric Oxide Measurement (PE Only) **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: April 2019 **Tab:** 26 **Specialty Developing Recommendation:** AAAAI, ACAAI, ATS, CHEST **First Identified:** October 2018 **2019 est Medicare Utilization:** 136,728

2021 Work RVU: 0.00
2021 NF PE RVU: 0.57
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95015 **Intracutaneous (intradermal) tests, sequential and incremental, with drugs, biologicals, or venoms, immediate type reaction, including test interpretation and report by a physician, specify number of tests** **Global:** **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 31 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2012 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95017 **Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests** **Global:** XXX **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 29 **Specialty Developing Recommendation:** JCAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 27,662

2021 Work RVU: 0.07
2021 NF PE RVU: 0.17
2021 Fac PE RVU: 0.03

RUC Recommendation: 0.07 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95018 **Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Percutaneous Allergy Testing **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 29 **Specialty Developing Recommendation:** JCAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 129,391

2021 Work RVU: 0.14
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.14 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95024 **Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI, AAOA **First Identified:** October 2010 **2019 est Medicare Utilization:** 1,833,929

2021 Work RVU: 0.01
2021 NF PE RVU: 0.23
2021 Fac PE RVU: 0.01

RUC Recommendation: New PE Inputs. **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95027 **Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests**

Global: XXX **Issue:** Intracutaneous Allgery Tests **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 41 **Specialty Developing Recommendation:** JCAAI, ACAAI, AAAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 164,524

2021 Work RVU: 0.01
2021 NF PE RVU: 0.12
2021 Fac PE RVU: NA

RUC Recommendation: 0.01 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95115 **Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection**

Global: XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 48 **Specialty Developing Recommendation:** JCAAI, AAOA **First Identified:** January 2012 **2019 est Medicare Utilization:** 1,034,318

2021 Work RVU: 0.00
2021 NF PE RVU: 0.26
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95117 **Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections**

Global: XXX **Issue:** Immunotherapy Injections **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 48 **Specialty Developing Recommendation:** JCAAI, AAOA **First Identified:** September 2011 **2019 est Medicare Utilization:** 2,769,382

2021 Work RVU: 0.00
2021 NF PE RVU: 0.32
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95144 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy, single dose vial(s) (specify number of vials)**

Global: XXX **Issue:** Antigen Therapy Services **Screen:** Low Value-Billed in Multiple Units / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 49 **Specialty Developing Recommendation:** AAOHNS, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 178,622

2021 Work RVU: 0.06
2021 NF PE RVU: 0.41
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95148 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy (specify number of doses); 4 single stinging insect venoms**

Global: XXX **Issue:** **Screen:** Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 73 **Specialty Developing Recommendation:** **First Identified:** October 2010 **2019 est Medicare Utilization:** 20,261

2021 Work RVU: 0.06
2021 NF PE RVU: 2.59
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95165 **Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses)**

Global: XXX **Issue:** Antigen Therapy Services **Screen:** MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 49 **Specialty Developing Recommendation:** AAOHNS, AAOA, ACAAI **First Identified:** October 2010 **2019 est Medicare Utilization:** 7,687,749

2021 Work RVU: 0.06
2021 NF PE RVU: 0.39
2021 Fac PE RVU: 0.02

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95249 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 08 **Specialty Developing Recommendation:** AACE, ES, ACP **First Identified:** **2019 est Medicare Utilization:** 10,730

2021 Work RVU: 0.00
2021 NF PE RVU: 1.64
2021 Fac PE RVU: NA

RUC Recommendation: PE Only. Referral to CPT Assistant **Referred to CPT** June 2017 **Result:** PE Only

Referred to CPT Asst ☑ **Published in CPT Asst:** June 2018

Status Report: CMS Requests and Relativity Assessment Issues

95250 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth2 / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACE, ES **First Identified:** October 2013 **2019 est Medicare Utilization:** 76,885

2021 Work RVU: 0.00
2021 NF PE RVU: 4.47
2021 Fac PE RVU: NA

RUC Recommendation: Re-review at RAW. New PE inputs. **Referred to CPT** October 2015 & February 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

95251 **Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report**

Global: XXX **Issue:** Continuous Glucose Monitoring **Screen:** High Volume Growth / Work Neutrality 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACE, ES **First Identified:** April 2013 **2019 est Medicare Utilization:** 248,288

2021 Work RVU: 0.70
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.28

RUC Recommendation: Re-review at RAW. 0.70. **Referred to CPT** February 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95700 **Electroencephalogram (eeg) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by eeg technologist, minimum of 8 channels**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95705 **Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, 2-12 hours; unmonitored**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95706 **Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, 2-12 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95707 **Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, 2-12 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95708 **Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, each increment of 12-26 hours; unmonitored**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95709 **Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95710 **Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95711 **Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, 2-12 hours; unmonitored**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95712 **Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, 2-12 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95713 **Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, 2-12 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95714 **Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, each increment of 12-26 hours; unmonitored**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95715 **Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95716 **Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

95717 **Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of eeg recording; without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.00
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.79

RUC Recommendation: 2.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95718 **Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of eeg recording; with video (veeg)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.50
2021 NF PE RVU: 1.25
2021 Fac PE RVU: 1.18

RUC Recommendation: 2.50 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95719 **Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of eeg recording, interpretation and report after each 24-hour period; without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 3.00
2021 NF PE RVU: 1.37
2021 Fac PE RVU: 1.32

RUC Recommendation: 3.00 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95720 **Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of eeg recording, interpretation and report after each 24-hour period; with video (veeg)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 3.86
2021 NF PE RVU: 1.91
2021 Fac PE RVU: 1.82

RUC Recommendation: 3.86 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95721 **Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of eeg recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 3.86
2021 NF PE RVU: 1.95
2021 Fac PE RVU: 1.83

RUC Recommendation: 3.86 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95722 **Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of eeg recording, with video (veeg)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.70
2021 NF PE RVU: 2.36
2021 Fac PE RVU: 2.22

RUC Recommendation: 4.70 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95723 **Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of eeg recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 4.75
2021 NF PE RVU: 2.45
2021 Fac PE RVU: 2.28

RUC Recommendation: 4.75 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95724 **Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of eeg recording, with video (veeg)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 6.00
2021 NF PE RVU: 3.02
2021 Fac PE RVU: 2.84

RUC Recommendation: 6.00 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95725 **Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of eeg recording, without video**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 5.40
2021 NF PE RVU: 2.82
2021 Fac PE RVU: 2.61

RUC Recommendation: 5.40 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95726 **Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of eeg recording, with video (veeg)**

Global: XXX **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 7.58
2021 NF PE RVU: 3.83
2021 Fac PE RVU: 3.59

RUC Recommendation: 7.58 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95800 **Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 24,715

2021 Work RVU: 0.85
2021 NF PE RVU: 3.98
2021 Fac PE RVU: NA

RUC Recommendation: 1.05 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95801 **Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 422

2021 Work RVU: 0.85
2021 NF PE RVU: 1.72
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95803 **Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** NA **2019 est Medicare Utilization:** 232

2021 Work RVU: 0.90
2021 NF PE RVU: 3.55
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 and New PE inputs **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95805 **Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,017

2021 Work RVU: 1.20
2021 NF PE RVU: 10.97
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95806 **Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 80,376

2021 Work RVU: 0.93
2021 NF PE RVU: 1.95
2021 Fac PE RVU: NA

RUC Recommendation: 1.28 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95807 **Sleep study, simultaneous recording of ventilation, respiratory effort, ecg or heart rate, and oxygen saturation, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 3,278

2021 Work RVU: 1.28
2021 NF PE RVU: 10.24
2021 Fac PE RVU: NA

RUC Recommendation: 1.25 **Referred to CPT** October 2009 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95808 **Polysomnography; any age, sleep staging with 1-3 additional parameters of sleep, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 1,197

2021 Work RVU: 1.74
2021 NF PE RVU: 17.45
2021 Fac PE RVU: NA

RUC Recommendation: 1.74 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95810 **Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing / MPC List **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** February 2010 **2019 est Medicare Utilization:** 272,131

2021 Work RVU: 2.50
2021 NF PE RVU: 15.30
2021 Fac PE RVU: NA

RUC Recommendation: 2.50 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95811 **Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist**

Global: XXX **Issue:** Sleep Testing **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: April 2010 **Tab:** 28 **Specialty Developing Recommendation:** ACNS, AAN, ACCP/ATS, AASM **First Identified:** October 2009 **2019 est Medicare Utilization:** 333,381

2021 Work RVU: 2.60
2021 NF PE RVU: 15.99
2021 Fac PE RVU: NA

RUC Recommendation: 2.60 **Referred to CPT** October 2009 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95812 **Electroencephalogram (eeg) extended monitoring; 41-60 minutes** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 24,822

2021 Work RVU: 1.08
2021 NF PE RVU: 8.96
2021 Fac PE RVU: NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95813 **Electroencephalogram (eeg) extended monitoring; 61-119 minutes** **Global:** XXX **Issue:** Long-Term EEG Monitoring **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:** 31,299

2021 Work RVU: 1.63
2021 NF PE RVU: 10.70
2021 Fac PE RVU: NA

RUC Recommendation: 1.63 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95816 **Electroencephalogram (eeg); including recording awake and drowsy** **Global:** XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 22 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:** 278,212

2021 Work RVU: 1.08
2021 NF PE RVU: 9.91
2021 Fac PE RVU: NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95819 **Electroencephalogram (eeg); including recording awake and asleep** **Global:** XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 22 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** September 2011 **2019 est Medicare Utilization:** 202,028

2021 Work RVU: 1.08
2021 NF PE RVU: 12.12
2021 Fac PE RVU: NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95822 **Electroencephalogram (eeg); recording in coma or sleep only**

Global: XXX **Issue:** Electroencephalogram **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 22 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** January 2012 **2019 est Medicare Utilization:** 26,955

2021 Work RVU: 1.08
2021 NF PE RVU: 10.95
2021 Fac PE RVU: NA

RUC Recommendation: 1.08 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95827 **Electroencephalogram (EEG); all night recording**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** May 2018 **2019 est Medicare Utilization:** 5,020

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95831 **Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2015 **2019 est Medicare Utilization:** 79,780

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95832 **Muscle testing, manual (separate procedure) with report; hand, with or without comparison with normal side**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 11,062

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95833 **Muscle testing, manual (separate procedure) with report; total evaluation of body, excluding hands**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 867

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95834 **Muscle testing, manual (separate procedure) with report; total evaluation of body, including hands**

Global: **Issue:** Muscle Testing **Screen:** High Volume Growth3 / CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** AAN, AANEM, AAPM, AAPMR, ACP, APTA **First Identified:** October 2017 **2019 est Medicare Utilization:** 605

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95860 **Needle electromyography; 1 extremity with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Harvard Valued - Utilization over 100,000 / Codes Reported Together 75% or More-Part1 / Harvard-Valued Annual Allowed Charges over $10 million **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2009 **2019 est Medicare Utilization:** 2,418

2021 Work RVU: 0.96
2021 NF PE RVU: 2.48
2021 Fac PE RVU: NA

RUC Recommendation: 0.96 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95861 **Needle electromyography; 2 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 44,204

2021 Work RVU: 1.54
2021 NF PE RVU: 3.43
2021 Fac PE RVU: NA

RUC Recommendation: 1.54 **Referred to CPT** February 2011 & October 2011 & February 2012 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95863 **Needle electromyography; 3 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 157

2021 Work RVU: 1.87
2021 NF PE RVU: 4.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.87 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95864 **Needle electromyography; 4 extremities with or without related paraspinal areas** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,620

2021 Work RVU: 1.99
2021 NF PE RVU: 5.25
2021 Fac PE RVU: NA

RUC Recommendation: 1.99 **Referred to CPT** February 2011 & October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95867 **Needle electromyography; cranial nerve supplied muscle(s), unilateral** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 1,113

2021 Work RVU: 0.79
2021 NF PE RVU: 2.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.79 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95868 **Needle electromyography; cranial nerve supplied muscles, bilateral** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 5,630

2021 Work RVU: 1.18
2021 NF PE RVU: 3.05
2021 Fac PE RVU: NA

RUC Recommendation: 1.18 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95869 **Needle electromyography; thoracic paraspinal muscles (excluding t1 or t12)** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2011 **2019 est Medicare Utilization:** 447

2021 Work RVU: 0.37
2021 NF PE RVU: 2.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95870 **Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters** **Global:** XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 19 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2011 **2019 est Medicare Utilization:** 52,835

2021 Work RVU: 0.37
2021 NF PE RVU: 2.28
2021 Fac PE RVU: NA

RUC Recommendation: 0.37 **Referred to CPT** October 2011 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95885 **Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; limited (list separately in addition to code for primary procedure)** **Global:** ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 141,249

2021 Work RVU: 0.35
2021 NF PE RVU: 1.59
2021 Fac PE RVU: NA

RUC Recommendation: 0.35 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95886 **Needle electromyography, each extremity, with related paraspinal areas, when performed, done with nerve conduction, amplitude and latency/velocity study; complete, five or more muscles studied, innervated by three or more nerves or four or more spinal levels (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 962,501

2021 Work RVU: 0.86
2021 NF PE RVU: 2.09
2021 Fac PE RVU: NA

RUC Recommendation: 0.92 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95887 **Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2011 **Tab:** 20 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, ACNS, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 14,870

2021 Work RVU: 0.71
2021 NF PE RVU: 1.84
2021 Fac PE RVU: NA

RUC Recommendation: 0.73 **Referred to CPT** February 2011 and October 2011 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95900 **Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** MPC List / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** October 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011& February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95903 **Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** CMS High Expenditure Procedural Codes1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 and February 2012 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95904 **Nerve conduction, amplitude and latency/velocity study, each nerve; sensory**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 / Low Value-Billed in Multiple Units **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2011 & October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95907 **Nerve conduction studies; 1-2 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 6,263

2021 Work RVU: 1.00
2021 NF PE RVU: 1.73
2021 Fac PE RVU: NA

RUC Recommendation: 1.00 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95908 **Nerve conduction studies; 3-4 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 58,348

2021 Work RVU: 1.25
2021 NF PE RVU: 2.20
2021 Fac PE RVU: NA

RUC Recommendation: 1.37 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95909 **Nerve conduction studies; 5-6 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 134,007

2021 Work RVU: 1.50
2021 NF PE RVU: 2.63
2021 Fac PE RVU: NA

RUC Recommendation: 1.77 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95910 **Nerve conduction studies; 7-8 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 157,766

2021 Work RVU: 2.00
2021 NF PE RVU: 3.41
2021 Fac PE RVU: NA

RUC Recommendation: 2.80 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95911 **Nerve conduction studies; 9-10 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 175,960

2021 Work RVU: 2.50
2021 NF PE RVU: 4.00
2021 Fac PE RVU: NA

RUC Recommendation: 3.34 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95912 **Nerve conduction studies; 11-12 studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 78,978

2021 Work RVU: 3.00
2021 NF PE RVU: 4.50
2021 Fac PE RVU: NA

RUC Recommendation: 4.00 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95913 **Nerve conduction studies; 13 or more studies**

Global: XXX **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** AAN, AAPMR, AANEM, APTA **First Identified:** **2019 est Medicare Utilization:** 81,707

2021 Work RVU: 3.56
2021 NF PE RVU: 5.15
2021 Fac PE RVU: NA

RUC Recommendation: 4.20 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95921 **Testing of autonomic nervous system function; cardiovagal innervation (parasympathetic function), including 2 or more of the following: heart rate response to deep breathing with recorded r-r interval, valsalva ratio, and 30:15 ratio**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 / Different Performing Specialty from Survey3 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** October 2009 **2019 est Medicare Utilization:** 54,178

2021 Work RVU: 0.90
2021 NF PE RVU: 1.66
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 0.90 **Referred to CPT** February 2012 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

95922 **Testing of autonomic nervous system function; vasomotor adrenergic innervation (sympathetic adrenergic function), including beat-to-beat blood pressure and r-r interval changes during valsalva maneuver and at least 5 minutes of passive tilt**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** High Volume Growth1 / CMS Fastest Growing / Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,986

2021 Work RVU: 0.96
2021 NF PE RVU: 2.08
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 0.96 **Referred to CPT** February 2012 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2008; Sep 2020

95923 **Testing of autonomic nervous system function; sudomotor, including 1 or more of the following: quantitative sudomotor axon reflex test (qsart), silastic sweat imprint, thermoregulatory sweat test, and changes in sympathetic skin potential**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth6 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** October 2019 **2019 est Medicare Utilization:** 114,086

2021 Work RVU: 0.90
2021 NF PE RVU: 2.88
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 0.90 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

Status Report: CMS Requests and Relativity Assessment Issues

95924 **Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAFP, AAN, AANEM, ACNS, ACP **First Identified:** **2019 est Medicare Utilization:** 21,055

2021 Work RVU: 1.73
2021 NF PE RVU: 2.58
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT Assistant. 1.73 **Referred to CPT** February 2012 **Result:** Decrease

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2020

95925 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR **First Identified:** February 2010 **2019 est Medicare Utilization:** 5,861

2021 Work RVU: 0.54
2021 NF PE RVU: 4.02
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 and New PE Inputs **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95926 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1/ CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, ACNS, AAPMR **First Identified:** February 2010 **2019 est Medicare Utilization:** 6,658

2021 Work RVU: 0.54
2021 NF PE RVU: 3.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.54 and New PE Inputs **Referred to CPT** October 2010 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95928 **Central motor evoked potential study (transcranial motor stimulation); upper limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 36 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 325

2021 Work RVU: 1.50
2021 NF PE RVU: 5.39
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95929 **Central motor evoked potential study (transcranial motor stimulation); lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request to Re-Review Families of Recently Reviewed CPT Codes / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: April 2013 **Tab:** 36 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,333

2021 Work RVU: 1.50
2021 NF PE RVU: 5.60
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95930 **Visual evoked potential (vep) checkerboard or flash testing, central nervous system except glaucoma, with interpretation and report**

Global: XXX **Issue:** Visual Evoked Potential Testing **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 11 **Specialty Developing Recommendation:** AAO, AOA (optometry), ACNS **First Identified:** October 2015 **2019 est Medicare Utilization:** 53,881

2021 Work RVU: 0.35
2021 NF PE RVU: 1.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.35 **Referred to CPT** May 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95934 **H-reflex, amplitude and latency study; record gastrocnemius/soleus muscle**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95936 **H-reflex, amplitude and latency study; record muscle other than gastrocnemius/soleus muscle**

Global: **Issue:** EMG in Conjunction with Nerve Testing **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: April 2012 **Tab:** 32 **Specialty Developing Recommendation:** **First Identified:** **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2011 & February 2012 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95938 **Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper and lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** January 2013 **2019 est Medicare Utilization:** 90,204

2021 Work RVU: 0.86

2021 NF PE RVU: 9.64

2021 Fac PE RVU: NA

RUC Recommendation: 0.86 and new PE inputs **Referred to CPT** October 2010 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95939 **Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs**

Global: XXX **Issue:** Evoked Potentials and Reflex Studies **Screen:** Codes Reported Together 75% or More-Part1 / CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 34 **Specialty Developing Recommendation:** AAN, AANEM, AAPMR, ACNS **First Identified:** January 2013 **2019 est Medicare Utilization:** 41,818

2021 Work RVU: 2.25
2021 NF PE RVU: 13.62
2021 Fac PE RVU: NA

RUC Recommendation: 2.25 and new PE inputs **Referred to CPT** October 2010 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95940 **Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (list separately in addition to code for primary procedure)**

Global: XXX **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:** 25,807

2021 Work RVU: 0.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.60 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

95941 **Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (list separately in addition to code for primary procedure)**

Global: XXX **Issue:** Intraoperative Neurophysiology Monitoring **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** 12 **Specialty Developing Recommendation:** **First Identified:** January 2012 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 2.00 **Referred to CPT** February 2012 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95943 **Simultaneous, independent, quantitative measures of both parasympathetic function and sympathetic function, based on time-frequency analysis of heart rate variability concurrent with time-frequency analysis of continuous respiratory activity, with mean heart rate and blood pressure measures, during rest, paced (deep) breathing, Valsalva maneuvers, and head-up postural change**

Global: XXX **Issue:** Autonomic Function Testing **Screen:** Codes Reported Together 75% or More-Part1 / Contractor Priced High Volume **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AAN, AANEM **First Identified:** January 2018 **2019 est Medicare Utilization:** 22,723

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: Deleted from CPT **Referred to CPT** October 2020 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95950 **Monitoring for identification and lateralization of cerebral seizure focus, electroencephalographic (eg, 8 channel EEG) recording and interpretation, each 24 hours**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2019 est Medicare Utilization:** 2,415

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

95951 **Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (eg, for presurgical localization), each 24 hours**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 188,070

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** May 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95953 **Monitoring for localization of cerebral seizure focus by computerized portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2009 **2019 est Medicare Utilization:** 24,927

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

95954 **Pharmacological or physical activation requiring physician or other qualified health care professional attendance during eeg recording of activation phase (eg, thiopental activation test)**

Global: XXX **Issue:** EEG Monitoring **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** S **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** February 2008 **2019 est Medicare Utilization:** 623

2021 Work RVU: 2.45
2021 NF PE RVU: 8.95
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

95956 **Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse**

Global: **Issue:** Long-Term EEG Monitoring **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 13 **Specialty Developing Recommendation:** AAN, ACNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 5,307

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2009

Status Report: CMS Requests and Relativity Assessment Issues

95957 **Digital analysis of electroencephalogram (eeg) (eg, for epileptic spike analysis)** **Global:** XXX **Issue:** Electroencephalogram (EEG) Exended Monitoring **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 50 **Specialty Developing Recommendation:** AAN **First Identified:** July 2015 **2019 est Medicare Utilization:** 61,055

2021 Work RVU: 1.98
2021 NF PE RVU: 5.29
2021 Fac PE RVU: NA

RUC Recommendation: 1.98 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

95970 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming** **Global:** XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / CMS Request - Final Rule for 2016 / High Volume Growth3 / CPT Assistant Analysis 2018 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 38,689

2021 Work RVU: 0.35
2021 NF PE RVU: 0.17
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.45 **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95971 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional** **Global:** XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AUA, ACOG, AAPM, SIS, ACNS **First Identified:** October 2009 **2019 est Medicare Utilization:** 21,590

2021 Work RVU: 0.78
2021 NF PE RVU: 0.59
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.78 **Referred to CPT** February 2015, June 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95972 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** Harvard Valued - Utilization over 100,000 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AUA, ACOG, AAPM, SIS, ACNS **First Identified:** February 2010 **2019 est Medicare Utilization:** 46,946

2021 Work RVU: 0.80
2021 NF PE RVU: 0.76
2021 Fac PE RVU: 0.31

RUC Recommendation: 0.80 **Referred to CPT** May 2014 February , June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

95973 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex spinal cord, or peripheral (ie, peripheral nerve, sacral nerve, neuromuscular) (except cranial nerve) neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Implanted Neurostimulator Electronic Analysis **Screen:** Harvard Valued - Utilization over 100,000 / Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: April 2015 **Tab:** 21 **Specialty Developing Recommendation:** AANS/CNS, ACOG, ASA, AUA, ISIS **First Identified:** February 2010 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95974 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95975 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude, pulse duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

Status Report: CMS Requests and Relativity Assessment Issues

95976 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 8,660

2021 Work RVU: 0.73
2021 NF PE RVU: 0.38
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.95 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

95977 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 7,130

2021 Work RVU: 0.97
2021 NF PE RVU: 0.50
2021 Fac PE RVU: 0.47

RUC Recommendation: 1.19 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

Status Report: CMS Requests and Relativity Assessment Issues

95978 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95979 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, battery status, electrode selectability and polarity, impedance and patient compliance measurements), complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour (List separately in addition to code for primary procedure)**

Global: **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jul 2016

95980 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 570

2021 Work RVU: 0.80
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.35

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95981 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 843

2021 Work RVU: 0.30
2021 NF PE RVU: 0.73
2021 Fac PE RVU: 0.17

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95982 **Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming**

Global: XXX **Issue:** Neurostimulator Services **Screen:** CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 07 **Specialty Developing Recommendation:** No Interest **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,278

2021 Work RVU: 0.65
2021 NF PE RVU: 0.93
2021 Fac PE RVU: 0.31

RUC Recommendation: Not part of family **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95983 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional**

Global: XXX **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 40,522

2021 Work RVU: 0.91
2021 NF PE RVU: 0.48
2021 Fac PE RVU: 0.45

RUC Recommendation: 1.25 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

Status Report: CMS Requests and Relativity Assessment Issues

95984 **Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Neurostimulator Services **Screen:** High Volume Growth2 / CMS Request - Final Rule for 2016 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 07 **Specialty Developing Recommendation:** AAN, AANS/CNS, ACNS **First Identified:** June 2017 **2019 est Medicare Utilization:** 58,079

2021 Work RVU: 0.80
2021 NF PE RVU: 0.41
2021 Fac PE RVU: 0.40

RUC Recommendation: 1.00 and Refer to CPT Assistant **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** February 2019

95990 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed;**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** Different Performing Specialty from Survey / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 07 **Specialty Developing Recommendation:** ASA, AAPM, NASS, AAMP&R, AANS/CNS, ISIS **First Identified:** April 2010 **2019 est Medicare Utilization:** 1,124

2021 Work RVU: 0.00
2021 NF PE RVU: 2.68
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

95991 **Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional**

Global: XXX **Issue:** Electronic Analysis Implanted Pump **Screen:** High Volume Growth1 / Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 07 **Specialty Developing Recommendation:** ASA, AAPM **First Identified:** February 2008 **2019 est Medicare Utilization:** 8,596

2021 Work RVU: 0.77
2021 NF PE RVU: 2.50
2021 Fac PE RVU: 0.32

RUC Recommendation: 0.77 **Referred to CPT** October 2010 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

95992 **Canalith repositioning procedure(s) (eg, epley maneuver, semont maneuver), per day**

Global: XXX **Issue:** **Screen:** Modifier -51 Exempt **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 33 **Specialty Developing Recommendation:** **First Identified:** January 2018 **2019 est Medicare Utilization:** 112,529

2021 Work RVU: 0.75
2021 NF PE RVU: 0.49
2021 Fac PE RVU: 0.28

RUC Recommendation: Remove from Modifier -51 Exempt list. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96101 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI, Rorschach, WAIS), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96102 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96103 **Psychological testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI), administered by a computer, with qualified health care professional interpretation and report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** High Volume Growth2 / Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96105 **Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, eg, by boston diagnostic aphasia examination) with interpretation and report, per hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS Request/Speech Language Pathology Request / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 1,273

2021 Work RVU: 1.75
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: 1.75 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96110 **Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96111 **Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report**

Global: **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96112 **Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour**

Global: XXX **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 1,417

2021 Work RVU: 2.56
2021 NF PE RVU: 1.07
2021 Fac PE RVU: 1.01

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96113 **Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuropsychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 132

2021 Work RVU: 1.16
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.35

RUC Recommendation: 1.10 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96116 **Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:** 157,733

2021 Work RVU: 1.86
2021 NF PE RVU: 0.83
2021 Fac PE RVU: 0.45

RUC Recommendation: 1.86 **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96118 **Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), per hour of the psychologist's or physician's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96119 **Neuropsychological testing (eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** July 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96120 **Neuropsychological testing (eg, Wisconsin Card Sorting Test), administered by a computer, with qualified health care professional interpretation and report**

Global: **Issue:** Psychological and Neuro-psychological Testing **Screen:** High Volume Growth2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** June 2017 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96121 **Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 47,794

2021 Work RVU: 1.71
2021 NF PE RVU: 0.56
2021 Fac PE RVU: 0.33

RUC Recommendation: 1.71 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96125 **Standardized cognitive performance testing (eg, ross information processing assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 4,262

2021 Work RVU: 1.70
2021 NF PE RVU: 1.28
2021 Fac PE RVU: NA

RUC Recommendation: 1.70 **Referred to CPT** June 2017 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96127 **Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [adhd] scale), with scoring and documentation, per standardized instrument**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** January 2016 **2019 est Medicare Utilization:** 492,372

2021 Work RVU: 0.00
2021 NF PE RVU: 0.13
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96130 **Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 99,759

2021 Work RVU: 2.56
2021 NF PE RVU: 0.79
2021 Fac PE RVU: 0.44

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

96131 **Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 80,133

2021 Work RVU: 1.96
2021 NF PE RVU: 0.57
2021 Fac PE RVU: 0.29

RUC Recommendation: 1.90 **Referred to CPT** June 2017 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

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96132 **Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 194,323

2021 Work RVU: 2.56
2021 NF PE RVU: 1.16
2021 Fac PE RVU: 0.38

RUC Recommendation: 2.50 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

96133 **Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 08 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 339,426

2021 Work RVU: 1.96
2021 NF PE RVU: 0.96
2021 Fac PE RVU: 0.27

RUC Recommendation: 1.90 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

96136 **Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 173,801

2021 Work RVU: 0.55
2021 NF PE RVU: 0.75
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.55 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96137 **Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 379,620

2021 Work RVU: 0.46
2021 NF PE RVU: 0.72
2021 Fac PE RVU: 0.06

RUC Recommendation: 0.46 **Referred to CPT** June 2017 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

96138 **Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 157,925

2021 Work RVU: 0.00
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

96139 **Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 353,021

2021 Work RVU: 0.00
2021 NF PE RVU: 1.06
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96146 **Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only**

Global: XXX **Issue:** Psychological and Neuro-psychological Testing **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: October 2017 **Tab:** 20 **Specialty Developing Recommendation:** APA (psychology), AAP, ASHA, AAN **First Identified:** June 2017 **2019 est Medicare Utilization:** 27,702

2021 Work RVU: 0.00
2021 NF PE RVU: 0.05
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** June 2017 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96150 **Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 54,601

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

96151 **Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 10,113

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

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96152 **Health and behavior intervention, each 15 minutes, face-to-face; individual**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 103,595

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96153 **Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** **First Identified:** September 2018 **2019 est Medicare Utilization:** 42,795

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96154 **Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:** APA (psychology), NASW **First Identified:** April 2017 **2019 est Medicare Utilization:** 8,583

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96155 **Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)**

Global: **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

96156 **Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 2.10
2021 NF PE RVU: 0.60
2021 Fac PE RVU: 0.28

RUC Recommendation: 2.10

Referred to CPT September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96158 **Health behavior intervention, individual, face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.45
2021 NF PE RVU: 0.41
2021 Fac PE RVU: 0.19

RUC Recommendation: 1.45

Referred to CPT September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96159 **Health behavior intervention, individual, face-to-face; each additional 15 minutes (list separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.50
2021 NF PE RVU: 0.14
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96164 **Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.21
2021 NF PE RVU: 0.06
2021 Fac PE RVU: 0.03

RUC Recommendation: 0.21 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96165 **Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (list separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.10
2021 NF PE RVU: 0.03
2021 Fac PE RVU: 0.01

RUC Recommendation: 0.10 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96167 **Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.55
2021 NF PE RVU: 0.44
2021 Fac PE RVU: 0.20

RUC Recommendation: 1.55 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96168 **Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.55
2021 NF PE RVU: 0.16
2021 Fac PE RVU: 0.07

RUC Recommendation: 0.55 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96170 **Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes**

Global: XXX **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 1.50
2021 NF PE RVU: 0.71
2021 Fac PE RVU: 0.58

RUC Recommendation: 1.50 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96171 **Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (list separately in addition to code for primary service)**

Global: ZZZ **Issue:** Health and Behavior Assessment and Intervention **Screen:** Negative IWPUT **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 41 **Specialty Developing Recommendation:**

First Identified: September 2018 **2019 est Medicare Utilization:**

2021 Work RVU: 0.54
2021 NF PE RVU: 0.26
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.54 **Referred to CPT** September 2018 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

96360 **Intravenous infusion, hydration; initial, 31 minutes to 1 hour**

Global: XXX **Issue:** IV Hydration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 25 **Specialty Developing Recommendation:** ASCO, ASH

First Identified: July 2015 **2019 est Medicare Utilization:** 248,266

2021 Work RVU: 0.17
2021 NF PE RVU: 0.85
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96361 **Intravenous infusion, hydration; each additional hour (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** IV Hydration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 25 **Specialty Developing Recommendation:** ASCO, ASH

First Identified: July 2015 **2019 est Medicare Utilization:** 433,535

2021 Work RVU: 0.09
2021 NF PE RVU: 0.30
2021 Fac PE RVU: NA

RUC Recommendation: 0.09 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96365 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); initial, up to 1 hour**

Global: XXX **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,269,889

2021 Work RVU: 0.21
2021 NF PE RVU: 1.86
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96366 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); each additional hour (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** April 2013 **2019 est Medicare Utilization:** 558,744

2021 Work RVU: 0.18
2021 NF PE RVU: 0.45
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96367 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** September 2011 **2019 est Medicare Utilization:** 1,292,846

2021 Work RVU: 0.19
2021 NF PE RVU: 0.71
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96368 **Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); concurrent infusion (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Intravenous Infusion Therapy **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 28 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ISDA **First Identified:** April 2013 **2019 est Medicare Utilization:** 133,379

2021 Work RVU: 0.17
2021 NF PE RVU: 0.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96372 **Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular**

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** Different Performing Specialty from Survey2 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH, AAFP, ACRh **First Identified:** April 2013 **2019 est Medicare Utilization:** 9,458,412

2021 Work RVU: 0.17
2021 NF PE RVU: 0.23
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96374 **Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug**

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 272,442

2021 Work RVU: 0.18
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96375 **Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,416,745

2021 Work RVU: 0.10
2021 NF PE RVU: 0.38
2021 Fac PE RVU: NA

RUC Recommendation: 0.10 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96377 **Application of on-body injector (includes cannula insertion) for timed subcutaneous injection**

Global: XXX **Issue:** Application of On-body Injector with Subcutaneous Injection **Screen:** should be on N/R LOI just added to track **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 26 **Specialty Developing Recommendation:** ASCO, ASH **First Identified:** January 2016 **2019 est Medicare Utilization:** 60,948

2021 Work RVU: 0.17
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** N/A **Result:** Not Part of RAW
Referred to CPT Asst ☐ **Published in CPT Asst:**

96401 **Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH, ACRh **First Identified:** July 2015 **2019 est Medicare Utilization:** 758,701

2021 Work RVU: 0.21
2021 NF PE RVU: 2.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** N/A **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96402 **Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH, AUA **First Identified:** July 2015 **2019 est Medicare Utilization:** 403,494

2021 Work RVU: 0.19
2021 NF PE RVU: 0.74
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 **Referred to CPT** N/A **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

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96405 **Chemotherapy administration; intralesional, up to and including 7 lesions**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2019 est Medicare Utilization:** 12,359

2021 Work RVU: 0.52
2021 NF PE RVU: 1.95
2021 Fac PE RVU: 0.28

RUC Recommendation: New PE inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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96406 **Chemotherapy administration; intralesional, more than 7 lesions**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 55 **Specialty Developing Recommendation:** ASCO **First Identified:** NA **2019 est Medicare Utilization:** 566

2021 Work RVU: 0.80
2021 NF PE RVU: 3.05
2021 Fac PE RVU: 0.45

RUC Recommendation: New PE inputs **Referred to CPT** **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** PE Only

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96409 **Chemotherapy administration; intravenous, push technique, single or initial substance/drug**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH **First Identified:** July 2015 **2019 est Medicare Utilization:** 79,884

2021 Work RVU: 0.24
2021 NF PE RVU: 2.95
2021 Fac PE RVU: NA

RUC Recommendation: 0.24 **Referred to CPT** N/A **Referred to CPT Asst** ☐ **Published in CPT Asst:** **Result:** Maintain

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Status Report: CMS Requests and Relativity Assessment Issues

96411 **Chemotherapy administration; intravenous, push technique, each additional substance/drug (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 27 **Specialty Developing Recommendation:** ASBMT, ASCO, ASH **First Identified:** July 2015 **2019 est Medicare Utilization:** 165,078

2021 Work RVU: 0.20
2021 NF PE RVU: 1.54
2021 Fac PE RVU: NA

RUC Recommendation: 0.20 **Referred to CPT** N/A **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96413 **Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** February 2010 **2019 est Medicare Utilization:** 1,875,219

2021 Work RVU: 0.28
2021 NF PE RVU: 3.88
2021 Fac PE RVU: NA

RUC Recommendation: 0.28 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

96415 **Chemotherapy administration, intravenous infusion technique; each additional hour (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** January 2012 **2019 est Medicare Utilization:** 891,855

2021 Work RVU: 0.19
2021 NF PE RVU: 0.69
2021 Fac PE RVU: NA

RUC Recommendation: 0.19 and new PE inputs **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96416 **Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump**

Global: XXX **Issue:** Chemotherapy Administration **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2010 **Tab:** 20 **Specialty Developing Recommendation:** ACRh, ASCO, ASH **First Identified:** February 2010 **2019 est Medicare Utilization:** 30,942

2021 Work RVU: 0.21
2021 NF PE RVU: 3.92
2021 Fac PE RVU: NA

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96417 **Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Chemotherapy Administration **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: January 2013 **Tab:** 29 **Specialty Developing Recommendation:** ACRh, ASCO, ASH, ASBMT **First Identified:** January 2012 **2019 est Medicare Utilization:** 388,626

2021 Work RVU: 0.21
2021 NF PE RVU: 1.81
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 and new PE inputs **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96440 **Chemotherapy administration into pleural cavity, requiring and including thoracentesis**

Global: 000 **Issue:** Chemotherapy Administration **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: February 2008 **Tab:** R **Specialty Developing Recommendation:** **First Identified:** NA **2019 est Medicare Utilization:** 60

2021 Work RVU: 2.12
2021 NF PE RVU: 25.94
2021 Fac PE RVU: 1.00

RUC Recommendation: New PE inputs **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96567 **Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day**

Global: XXX **Issue:** Photodynamic Therapy **Screen:** High Volume Growth1 / CMS Fastest Growing / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 16 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 66,951

2021 Work RVU: 0.00
2021 NF PE RVU: 4.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 PE Only **Referred to CPT** September 2016 **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

96573 **Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day**

Global: 000 **Issue:** Photodynamic Therapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 16 **Specialty Developing Recommendation:** AAD **First Identified:** January 2017 **2019 est Medicare Utilization:** 39,219

2021 Work RVU: 0.48
2021 NF PE RVU: 6.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

96574 **Debridement of premalignant hyperkeratotic lesion(s) (ie, targeted curettage, abrasion) followed with photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitizing drug(s) provided by a physician or other qualified health care professional, per day**

Global: 000 **Issue:** Photodynamic Therapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 16 **Specialty Developing Recommendation:** AAD **First Identified:** January 2017 **2019 est Medicare Utilization:** 48,673

2021 Work RVU: 1.01
2021 NF PE RVU: 7.44
2021 Fac PE RVU: NA

RUC Recommendation: 1.01 **Referred to CPT** September 2016 **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

96910 **Photochemotherapy; tar and ultraviolet b (goeckerman treatment) or petrolatum and ultraviolet b**

Global: XXX **Issue:** Photo-chemotherapy **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 44 **Specialty Developing Recommendation:** AAD **First Identified:** July 2015 **2019 est Medicare Utilization:** 386,553

2021 Work RVU: 0.00
2021 NF PE RVU: 3.48
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

96920 **Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm**

Global: 000 **Issue:** Laser Treatment – Skin **Screen:** CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2019 est Medicare Utilization:** 118,570

2021 Work RVU: 1.15
2021 NF PE RVU: 3.56
2021 Fac PE RVU: 0.66

RUC Recommendation: 1.15. Review in two years (Jan 2022) **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

96921 **Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm**

Global: 000 **Issue:** Laser Treatment – Skin **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** February 2008 **2019 est Medicare Utilization:** 29,878

2021 Work RVU: 1.30
2021 NF PE RVU: 3.85
2021 Fac PE RVU: 0.74

RUC Recommendation: 1.30. Review in two years (Jan 2022) **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

Status Report: CMS Requests and Relativity Assessment Issues

96922 **Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm** **Global:** 000 **Issue:** Laser Treatment – Skin **Screen:** High Volume Growth1 / CMS Fastest Growing / CPT Assistant Analysis **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAD **First Identified:** October 2008 **2019 est Medicare Utilization:** 15,528

2021 Work RVU: 2.10
2021 NF PE RVU: 4.86
2021 Fac PE RVU: 1.19

RUC Recommendation: 2.10. Review in two years (Jan 2022) **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Sep 2016

96X70 **Global:** **Issue:** Caregiver Behavior Management Training **Screen:** RUC Flag for Review **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 11 **Specialty Developing Recommendation:** AACAP, AND, APA (psychology) **First Identified:** April 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Review action plan **Referred to CPT** **Result:** Not part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

96X71 **Global:** **Issue:** Caregiver Behavior Management Training **Screen:** RUC Flag for Review **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 11 **Specialty Developing Recommendation:** **First Identified:** April 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Review action plan **Referred to CPT** **Result:** Not part of RAW

Referred to CPT Asst ☐ **Published in CPT Asst:**

97001 **Physical therapy evaluation** **Global:** **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97002 **Physical therapy re-evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

97003 **Occupational therapy evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

97004 **Occupational therapy re-evaluation**

Global: **Issue:** Physical Medicine and Rehabilitation Workgroup **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: February 2015 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** February 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97010 **Application of a modality to 1 or more areas; hot or cold packs**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 0.06
2021 NF PE RVU: 0.11
2021 Fac PE RVU: NA

RUC Recommendation: No specialty society interest **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97012 **Application of a modality to 1 or more areas; traction, mechanical**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 560,317

2021 Work RVU: 0.25
2021 NF PE RVU: 0.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97014 **Application of a modality to 1 or more areas; electrical stimulation (unattended)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 0.18
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97016 **Application of a modality to 1 or more areas; vasopneumatic devices**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Codes Reported Together 75% or More-Part1 / High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 864,521

2021 Work RVU: 0.18
2021 NF PE RVU: 0.16
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97018 **Application of a modality to 1 or more areas; paraffin bath**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Codes Reported Together 75% or More-Part1 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 174,530

2021 Work RVU: 0.06
2021 NF PE RVU: 0.10
2021 Fac PE RVU: NA

RUC Recommendation: 0.06 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97022 **Application of a modality to 1 or more areas; whirlpool**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 193,036

2021 Work RVU: 0.17
2021 NF PE RVU: 0.34
2021 Fac PE RVU: NA

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97032 **Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** July 2015 **2019 est Medicare Utilization:** 849,666

2021 Work RVU: 0.25
2021 NF PE RVU: 0.17
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97033 **Application of a modality to 1 or more areas; iontophoresis, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 56,451

2021 Work RVU: 0.26
2021 NF PE RVU: 0.32
2021 Fac PE RVU: NA

RUC Recommendation: 0.26 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97034 **Application of a modality to 1 or more areas; contrast baths, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 8,235

2021 Work RVU: 0.21
2021 NF PE RVU: 0.21
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97035 **Application of a modality to 1 or more areas; ultrasound, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Modalities **Screen:** Low Value-High Volume / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** October 2010 **2019 est Medicare Utilization:** 2,002,641

2021 Work RVU: 0.21
2021 NF PE RVU: 0.20
2021 Fac PE RVU: NA

RUC Recommendation: 0.21 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97110 **Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** Codes Reported Together 75% or More-Part1 / MPC List / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 60,569,850

2021 Work RVU: 0.45
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97112 **Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** September 2011 **2019 est Medicare Utilization:** 18,084,367

2021 Work RVU: 0.50
2021 NF PE RVU: 0.49
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97113 **Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** July 2015 **2019 est Medicare Utilization:** 1,811,269

2021 Work RVU: 0.48
2021 NF PE RVU: 0.60
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97116 **Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** Codes Reported Together 75% or More-Part1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** February 2010 **2019 est Medicare Utilization:** 2,661,789

2021 Work RVU: 0.45
2021 NF PE RVU: 0.40
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97127 **Therapeutic interventions that focus on cognitive function (eg, attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (eg, managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact**

Global: **Issue:** Cognitive Function Intervention **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** January 2017 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: 1.50 **Referred to CPT** September 2016 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97140 **Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA

First Identified: September 2011

2019 est Medicare Utilization: 29,711,740

2021 Work RVU: 0.43
2021 NF PE RVU: 0.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.43

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

97150 **Therapeutic procedure(s), group (2 or more individuals)**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: January 2012 **Tab:** **Specialty Developing Recommendation:** APTA

First Identified: April 2011

2019 est Medicare Utilization: 1,433,348

2021 Work RVU: 0.29
2021 NF PE RVU: 0.22
2021 Fac PE RVU: NA

RUC Recommendation: 0.29

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Increase

97161 **Physical therapy evaluation: low complexity, requiring these components: a history with no personal factors and/or comorbidities that impact the plan of care; an examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; a clinical presentation with stable and/or uncomplicated characteristics; and clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. typically, 20 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA

First Identified: February 2015

2019 est Medicare Utilization: 1,552,998

2021 Work RVU: 1.54
2021 NF PE RVU: 1.33
2021 Fac PE RVU: NA

RUC Recommendation: 0.75

Referred to CPT February 2015
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Decrease

Status Report: CMS Requests and Relativity Assessment Issues

97162 **Physical therapy evaluation: moderate complexity, requiring these components: a history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; an examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; an evolving clinical presentation with changing characteristics; and clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 1,386,353

2021 Work RVU: 1.54
2021 NF PE RVU: 1.33
2021 Fac PE RVU: NA

RUC Recommendation: 1.18 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

97163 **Physical therapy evaluation: high complexity, requiring these components: a history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; an examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; a clinical presentation with unstable and unpredictable characteristics; and clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. typically, 45 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 318,604

2021 Work RVU: 1.54
2021 NF PE RVU: 1.33
2021 Fac PE RVU: NA

RUC Recommendation: 1.50 **Referred to CPT** February 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97164 **Re-evaluation of physical therapy established plan of care, requiring these components: an examination including a review of history and use of standardized tests and measures is required; and revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome typically, 20 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 585,829

2021 Work RVU: 0.96
2021 NF PE RVU: 1.00
2021 Fac PE RVU: NA

RUC Recommendation: 0.75 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97165 **Occupational therapy evaluation, low complexity, requiring these components: an occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; an assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. patient presents with no comorbidities that affect occupational performance. modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 146,443

2021 Work RVU: 1.54
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.88 **Referred to CPT** February 2015 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97166 **Occupational therapy evaluation, moderate complexity, requiring these components: an occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; an assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. patient may present with comorbidities that affect occupational performance. minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. typically, 45 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 101,883

2021 Work RVU: 1.54
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 1.20 **Referred to CPT** February 2015 **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97167 **Occupational therapy evaluation, high complexity, requiring these components: an occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; an assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. patient presents with comorbidities that affect occupational performance. significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. typically, 60 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 22,637

2021 Work RVU: 1.54
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 1.70 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97168 **Re-evaluation of occupational therapy established plan of care, requiring these components: an assessment of changes in patient functional or medical status with revised plan of care; an update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. a formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. typically, 30 minutes are spent face-to-face with the patient and/or family.**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 17 **Specialty Developing Recommendation:** AOTA, APTA **First Identified:** February 2015 **2019 est Medicare Utilization:** 33,480

2021 Work RVU: 0.96
2021 NF PE RVU: 0.91
2021 Fac PE RVU: NA

RUC Recommendation: 0.80 **Referred to CPT** February 2015 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97530 **Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** CMS High Expenditure Procedural Codes1 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** September 2011 **2019 est Medicare Utilization:** 20,151,706

2021 Work RVU: 0.44
2021 NF PE RVU: 0.67
2021 Fac PE RVU: NA

RUC Recommendation: 0.44 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

97532 **Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes**

Global: **Issue:** Cognitive Function Intervention **Screen:** High Volume Growth2 / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA, ASHA, APA (psychology) **First Identified:** April 2013 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97533 **Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 21,250

2021 Work RVU: 0.48
2021 NF PE RVU: 1.24
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97535 **Self-care/home management training (eg, activities of daily living (adl) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Codes Reported Together 75% or More-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** October 2012 **2019 est Medicare Utilization:** 1,942,480

2021 Work RVU: 0.45
2021 NF PE RVU: 0.50
2021 Fac PE RVU: NA

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☑ **Published in CPT Asst:** Article no longer necessary

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97537 **Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - ADL/IADL **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 23,275

2021 Work RVU: 0.48
2021 NF PE RVU: 0.43
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97542 **Wheelchair management (eg, assessment, fitting, training), each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Therapeutic **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2013 **2019 est Medicare Utilization:** 61,278

2021 Work RVU: 0.48
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97597 **Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less**

Global: 000 **Issue:** Open Wound Debridement **Screen:** Site of Service Anomaly / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 23 **Specialty Developing Recommendation:** AAFP, ACS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 897,614

2021 Work RVU: 0.77
2021 NF PE RVU: 2.12
2021 Fac PE RVU: 0.22

RUC Recommendation: 0.88 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97598 **Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Open Wound Debridement **Screen:** Site of Service Anomaly / High Volume Growth3 / Different Performing Specialty from Survey **Complete?** Yes

Most Recent RUC Meeting: October 2018 **Tab:** 23 **Specialty Developing Recommendation:** AAFP, ACS, APMA **First Identified:** September 2007 **2019 est Medicare Utilization:** 135,670

2021 Work RVU: 0.50
2021 NF PE RVU: 0.79
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97602 **Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Active Wound Care Management **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** AAOS, ACS, APMA, ASPS **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97605 **Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (dme), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** AAOS, ACS, APMA, ASPS **First Identified:** April 2013 **2019 est Medicare Utilization:** 51,268

2021 Work RVU: 0.55
2021 NF PE RVU: 0.67
2021 Fac PE RVU: 0.16

RUC Recommendation: 0.55 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

97606 **Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (dme), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** April 2013 **2019 est Medicare Utilization:** 15,612

2021 Work RVU: 0.60
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.60 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97607 **Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** May 2013 **2019 est Medicare Utilization:** 5,825

2021 Work RVU: 0.41
2021 NF PE RVU: 9.58
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

97608 **Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters**

Global: XXX **Issue:** Negative Pressure Wound Therapy **Screen:** High Volume Growth2 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APMA, ACS, AAOS, ASPS **First Identified:** May 2013 **2019 est Medicare Utilization:** 1,172

2021 Work RVU: 0.46
2021 NF PE RVU: 9.26
2021 Fac PE RVU: 0.19

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

97610 **Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Active Wound Care Management **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:** 12,331

2021 Work RVU: 0.40
2021 NF PE RVU: 11.52
2021 Fac PE RVU: 0.12

RUC Recommendation: Maintain **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97755 **Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Tests and Measures **Screen:** High Volume Growth1 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** February 2008 **2019 est Medicare Utilization:** 2,693

2021 Work RVU: 0.62
2021 NF PE RVU: 0.47
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

97760 **Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes**

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 57,907

2021 Work RVU: 0.50
2021 NF PE RVU: 0.92
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97761 **Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes**

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,698

2021 Work RVU: 0.50
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: 0.50 **Referred to CPT** September 2016 **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97762 **Checkout for orthotic/prosthetic use, established patient, each 15 minutes**

Global: **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

97763 **Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes**

Global: XXX **Issue:** Orthotic Management and Prosthetic Training **Screen:** Physical Medicine and Rehabilitation Services **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA, AOTA **First Identified:** April 2016 **2019 est Medicare Utilization:** 38,754

2021 Work RVU: 0.48
2021 NF PE RVU: 1.08
2021 Fac PE RVU: NA

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

97802 **Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2019 est Medicare Utilization:** 224,711

2021 Work RVU: 0.53
2021 NF PE RVU: 0.53
2021 Fac PE RVU: 0.40

RUC Recommendation: 0.53 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

97803 **Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Request - Medical Nutrition Therapy **Complete?** Yes

Most Recent RUC Meeting: April 2008 **Tab:** 53 **Specialty Developing Recommendation:** ADA, AGA, AACE **First Identified:** NA **2019 est Medicare Utilization:** 211,418

2021 Work RVU: 0.45
2021 NF PE RVU: 0.46
2021 Fac PE RVU: 0.34

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98925 **Osteopathic manipulative treatment (omt); 1-2 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA **First Identified:** February 2010 **2019 est Medicare Utilization:** 65,014

2021 Work RVU: 0.46
2021 NF PE RVU: 0.42
2021 Fac PE RVU: 0.20

RUC Recommendation: 0.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98926 **Osteopathic manipulative treatment (omt); 3-4 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2019 est Medicare Utilization:** 109,622

2021 Work RVU: 0.71
2021 NF PE RVU: 0.55
2021 Fac PE RVU: 0.28

RUC Recommendation: 0.75 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98927 **Osteopathic manipulative treatment (omt); 5-6 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA **First Identified:** October 2009 **2019 est Medicare Utilization:** 99,716

2021 Work RVU: 0.96
2021 NF PE RVU: 0.69
2021 Fac PE RVU: 0.35

RUC Recommendation: 1.00 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

98928 **Osteopathic manipulative treatment (omt); 7-8 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA

First Identified: February 2010 **2019 est Medicare Utilization:** 99,045

2021 Work RVU: 1.21
2021 NF PE RVU: 0.81
2021 Fac PE RVU: 0.44

RUC Recommendation: 1.25 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98929 **Osteopathic manipulative treatment (omt); 9-10 body regions involved**

Global: 000 **Issue:** Osteopathic Manipulative Treatment **Screen:** Harvard Valued - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: February 2011 **Tab:** 34 **Specialty Developing Recommendation:** AOA

First Identified: February 2010 **2019 est Medicare Utilization:** 76,576

2021 Work RVU: 1.46
2021 NF PE RVU: 0.94
2021 Fac PE RVU: 0.53

RUC Recommendation: 1.50 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98940 **Chiropractic manipulative treatment (cmt); spinal, 1-2 regions**

Global: 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA

First Identified: September 2011 **2019 est Medicare Utilization:** 5,600,246

2021 Work RVU: 0.46
2021 NF PE RVU: 0.34
2021 Fac PE RVU: 0.17

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98941 **Chiropractic manipulative treatment (cmt); spinal, 3-4 regions**

Global: 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA

First Identified: September 2011 **2019 est Medicare Utilization:** 13,626,398

2021 Work RVU: 0.71
2021 NF PE RVU: 0.44
2021 Fac PE RVU: 0.26

RUC Recommendation: 0.71 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

98942 **Chiropractic manipulative treatment (cmt); spinal, 5 regions**

Global: 000 **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA **First Identified:** September 2011 **2019 est Medicare Utilization:** 948,986

2021 Work RVU: 0.96
2021 NF PE RVU: 0.54
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.96 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

98943 **Chiropractic manipulative treatment (cmt); extraspinal, 1 or more regions**

Global: XXX **Issue:** Chiropractic Manipulative Treatment **Screen:** CMS High Expenditure Procedural Codes1 **Complete?** Yes

Most Recent RUC Meeting: October 2012 **Tab:** 25 **Specialty Developing Recommendation:** ACA **First Identified:** September 2011 **2019 est Medicare Utilization:**

2021 Work RVU: 0.46
2021 NF PE RVU: 0.29
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.46 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

99143 **Deleted from CPT**

Global: **Issue:** Moderate Sedation **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99144 **Deleted from CPT**

Global: **Issue:** Moderate Sedation **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99148 **Deleted from CPT**

Global: **Issue:** Moderate Sedation **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99149 **Deleted from CPT**

Global: **Issue:** Moderate Sedation **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99150 **Deleted from CPT**

Global: **Issue:** Moderate Sedation **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

99151 **Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age**

Global: XXX **Issue:** Moderate Sedation **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 11

2021 Work RVU: 0.50
2021 NF PE RVU: 1.99
2021 Fac PE RVU: 0.18

RUC Recommendation: 0.50

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Maintain

Status Report: CMS Requests and Relativity Assessment Issues

99152 **Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older**

Global: XXX **Issue:** Moderate Sedation **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,909,615

2021 Work RVU: 0.25
2021 NF PE RVU: 1.24
2021 Fac PE RVU: 0.09

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99155 **Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age**

Global: XXX **Issue:** Moderate Sedation **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 30

2021 Work RVU: 1.90
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.32

RUC Recommendation: 1.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99156 **Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older**

Global: XXX **Issue:** Moderate Sedation **Screen:** Moderate Sedation Review **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 14 **Specialty Developing Recommendation:** AAP, AAOMS, ACC, CHEST, ACEP, ACG, ACR, AGA, ASGE, ASA, ATS, HRS, SIR, SVS, SCAI **First Identified:** January 2014 **2019 est Medicare Utilization:** 7,955

2021 Work RVU: 1.65
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.41

RUC Recommendation: 1.84 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

99174 **Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with remote analysis and report**

Global: XXX **Issue:** Instrument-Based Ocular Screening (PE Only) **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 09 **Specialty Developing Recommendation:** AAP, AAO **First Identified:** NA **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.15
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** May 2014 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

99177 **Instrument-based ocular screening (eg, photoscreening, automated-refraction), bilateral; with on-site analysis**

Global: XXX **Issue:** Instrument-Based Ocular Screening (PE Only) **Screen:** CMS Request - Practice Expense Review **Complete?** Yes

Most Recent RUC Meeting: September 2014 **Tab:** 09 **Specialty Developing Recommendation:** **First Identified:** May 2014 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.12
2021 Fac PE RVU: NA

RUC Recommendation: PE Only **Referred to CPT** May 2014 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99183 **Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session**

Global: XXX **Issue:** Hyperbaric Oxygen Therapy **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 33 **Specialty Developing Recommendation:** ACEP, ACP, ACS, APMA **First Identified:** April 2013 **2019 est Medicare Utilization:** 386,280

2021 Work RVU: 2.11
2021 NF PE RVU: 0.78
2021 Fac PE RVU: 0.78

RUC Recommendation: 2.11 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

99281 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a problem focused history; a problem focused examination; and straightforward medical decision making. counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. usually, the presenting problem(s) are self limited or minor.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 67,730

2021 Work RVU: 0.48
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.11

RUC Recommendation: 0.48 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

99282 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. usually, the presenting problem(s) are of low to moderate severity.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 352,496

2021 Work RVU: 0.93
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.21

RUC Recommendation: 0.93 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99283 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. usually, the presenting problem(s) are of moderate severity.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 2,744,710

2021 Work RVU: 1.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.33

RUC Recommendation: 1.42 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

99284 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 5,415,650

2021 Work RVU: 2.74
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.54

RUC Recommendation: 2.60 **Referred to CPT** **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99285 **Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: a comprehensive history; a comprehensive examination; and medical decision making of high complexity. counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.**

Global: XXX **Issue:** ED Visits **Screen:** CMS Request - Final Rule for 2018 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 29 **Specialty Developing Recommendation:** AAP, ACEP **First Identified:** June 2017 **2019 est Medicare Utilization:** 11,514,274

2021 Work RVU: 4.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.75

RUC Recommendation: 3.80 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

99358 **Prolonged evaluation and management service before and/or after direct patient care; first hour**

Global: XXX **Issue:** Prolonged Services - Without Direct Patient Contact **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 14 **Specialty Developing Recommendation:** AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS **First Identified:** November 2019 **2019 est Medicare Utilization:** 211,314

2021 Work RVU: 2.10
2021 NF PE RVU: 0.95
2021 Fac PE RVU: 0.95

RUC Recommendation: 1.80 **Referred to CPT** February 2021 **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99359 **Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (list separately in addition to code for prolonged service)**

Global: ZZZ **Issue:** Prolonged Services - Without Direct Patient Contact **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 14 **Specialty Developing Recommendation:** AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS **First Identified:** November 2019 **2019 est Medicare Utilization:** 7,861

2021 Work RVU: 1.00
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.47

RUC Recommendation: 0.75 **Referred to CPT** February 2021 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

99363 **Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)**

Global: **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

99364 **Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; each subsequent 90 days of therapy (must include a minimum of 3 INR measurements)**

Global: **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** **First Identified:** September 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2016 **Result:** Deleted from CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99375 **Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 1.73
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.67

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

99378 **Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU: 1.73
2021 NF PE RVU: 1.13
2021 Fac PE RVU: 0.67

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

993X0

Global: **Issue:** Prolonged Services - on the date of an E/M **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2022 **Tab:** **Specialty Developing Recommendation:** AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS **First Identified:** February 2021 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Survey **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

99415 **Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (list separately in addition to code for outpatient evaluation and management service)**

Global: ZZZ **Issue:** Prolonged Services - Clinical Staff Services (PE Only) **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS **First Identified:** **2019 est Medicare Utilization:** 4,248

2021 Work RVU: 0.00
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** February 2022 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

99416 **Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (list separately in addition to code for prolonged service)**

Global: ZZZ **Issue:** Prolonged Services - Clinical Staff Services (PE Only) **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 15 **Specialty Developing Recommendation:** AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS **First Identified:** **2019 est Medicare Utilization:** 1,382

2021 Work RVU: 0.00
2021 NF PE RVU: 0.15
2021 Fac PE RVU: NA

RUC Recommendation: New PE Inputs **Referred to CPT** February 2022 **Result:** PE Only
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99417 **Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (list separately in addition to codes 99205, 99215 for office or other outpatient evaluation and management services)**

Global: XXX **Issue:** Prolonged Services - on the date of an E/M **Screen:** CMS Request - Final Rule for 2020 **Complete?** No

Most Recent RUC Meeting: January 2022 **Tab:** **Specialty Developing Recommendation:** AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS **First Identified:** November 2021 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Survey **Referred to CPT** February 2021 **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

99491 **Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.**

Global: XXX **Issue:** Chronic Care Management Services **Screen:** New and Revised Service (Not part of RAW) **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 09 **Specialty Developing Recommendation:** AAFP, AAN, ACP, AGS **First Identified:** NA **2019 est Medicare Utilization:** 48,091

2021 Work RVU: 1.45
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.82

RUC Recommendation: 1.45. Refer to CPT Assistant **Referred to CPT** **Result:** Not part of RAW
Referred to CPT Asst ☑ **Published in CPT Asst:** Oct 2018

Status Report: CMS Requests and Relativity Assessment Issues

99492 **Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.**

Global: XXX **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 16,445

2021 Work RVU: 1.88
2021 NF PE RVU: 2.41
2021 Fac PE RVU: 0.68

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99493 **Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.**

Global: XXX **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 14,660

2021 Work RVU: 2.05
2021 NF PE RVU: 2.24
2021 Fac PE RVU: 0.76

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

99494 **Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Psychiatric Collaborative Care Management Services **Screen:** Work Neutrality 2018 **Complete?** No

Most Recent RUC Meeting: January 2020 **Tab:** 37 **Specialty Developing Recommendation:** AACAP, AAFP, AAP, ACP, APA (psychiatry) **First Identified:** October 2019 **2019 est Medicare Utilization:** 27,335

2021 Work RVU: 0.82
2021 NF PE RVU: 0.82
2021 Fac PE RVU: 0.30

RUC Recommendation: CMS investigate and review for New Tech/New Svc in Oct 2022.

Referred to CPT **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

99497 **Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate**

Global: XXX **Issue:** Advance Care Planning **Screen:** RUC Referral to CPT Assistant **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAFP, AAN, ACP, ACCP, AGS, ATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 1,825,276

2021 Work RVU: 1.50
2021 NF PE RVU: 0.86
2021 Fac PE RVU: 0.65

RUC Recommendation: Review in 2 years **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2014

99498 **Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)**

Global: ZZZ **Issue:** Advance Care Planning **Screen:** RUC Referral to CPT Assistant **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:** AAFP, AAN, ACP, ACCP, AGS, ATS **First Identified:** January 2014 **2019 est Medicare Utilization:** 60,204

2021 Work RVU: 1.40
2021 NF PE RVU: 0.64
2021 Fac PE RVU: 0.63

RUC Recommendation: Review in 2 years **Referred to CPT** **Result:**
Referred to CPT Asst ☑ **Published in CPT Asst:** Dec 2014

G0008 **Administration of influenza virus vaccine**

Global: XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0009 **Administration of pneumococcal vaccine** **Global:** XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0010 **Administration of hepatitis b vaccine** **Global:** XXX **Issue:** Immunization Administration **Screen:** CMS Request-Final Rule for 2021 **Complete?** Yes

Most Recent RUC Meeting: April 2021 **Tab:** 19 **Specialty Developing Recommendation:** AAFP, AAP, ACOG, ACP, ANA **First Identified:** July 2020 **2019 est Medicare Utilization:**

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: 0.17 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0101 **Cervical or vaginal cancer screening; pelvic and clinical breast examination** **Global:** XXX **Issue:** **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** ACOG **First Identified:** October 2010 **2019 est Medicare Utilization:** 929,962

2021 Work RVU: 0.45
2021 NF PE RVU: 0.63
2021 Fac PE RVU: 0.29

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0102 **Prostate cancer screening; digital rectal examination** **Global:** XXX **Issue:** RAW **Screen:** High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 30 **Specialty Developing Recommendation:** **First Identified:** October 2016 **2019 est Medicare Utilization:** 30,358

2021 Work RVU: 0.18
2021 NF PE RVU: 0.47
2021 Fac PE RVU: 0.07

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0104 **Colorectal cancer screening; flexible sigmoidoscopy** **Global:** 000 **Issue:** Flexible Sigmoidoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 09 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, SAGES, ACS **First Identified:** January 2014 **2019 est Medicare Utilization:** 2,724

2021 Work RVU: 0.84
2021 NF PE RVU: 4.65
2021 Fac PE RVU: 0.67

RUC Recommendation: 0.84 **Referred to CPT** October 2013 **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0105 **Colorectal cancer screening; colonoscopy on individual at high risk** **Global:** 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 262,478

2021 Work RVU: 3.26
2021 NF PE RVU: 6.56
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Decrease
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0108 **Diabetes outpatient self-management training services, individual, per 30 minutes** **Global:** XXX **Issue:** Diabetes Management Training **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41iv **Specialty Developing Recommendation:** AND **First Identified:** April 2016 **2019 est Medicare Utilization:** 172,612

2021 Work RVU: 0.90
2021 NF PE RVU: 0.66
2021 Fac PE RVU: NA

RUC Recommendation: 0.90 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0109 **Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes** **Global:** XXX **Issue:** Diabetes Management Training **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 41iv **Specialty Developing Recommendation:** AND **First Identified:** April 2016 **2019 est Medicare Utilization:** 111,248

2021 Work RVU: 0.25
2021 NF PE RVU: 0.19
2021 Fac PE RVU: NA

RUC Recommendation: 0.25 **Referred to CPT** **Result:** Maintain
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0121 **Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk**

Global: 000 **Issue:** Colonoscopy **Screen:** MPC List **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 10 **Specialty Developing Recommendation:** AGA, ASGE, ACG, ASCRS, ACS, SAGES **First Identified:** September 2011 **2019 est Medicare Utilization:** 215,409

2021 Work RVU: 3.26
2021 NF PE RVU: 6.56
2021 Fac PE RVU: 1.73

RUC Recommendation: 3.36 **Referred to CPT** **Result:** Decrease

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0124 **Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP **First Identified:** October 2017 **2019 est Medicare Utilization:** 47,978

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0127 **Trimming of dystrophic nails, any number**

Global: 000 **Issue:** **Screen:** CMS-Other - Utilization over 500,000 **Complete?** Yes

Most Recent RUC Meeting: September 2011 **Tab:** 51 **Specialty Developing Recommendation:** APMA **First Identified:** April 2011 **2019 est Medicare Utilization:** 1,109,311

2021 Work RVU: 0.17
2021 NF PE RVU: 0.52
2021 Fac PE RVU: 0.04

RUC Recommendation: Remove from screen **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0141 **Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP **First Identified:** October 2017 **2019 est Medicare Utilization:** 3,666

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0166 **External counterpulsation, per treatment session**

Global: XXX **Issue:** External Counterpulsation **Screen:** CMS-Other - Utilization over 100,000 / CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 14 **Specialty Developing Recommendation:** ACC **First Identified:** April 2016 **2019 est Medicare Utilization:** 95,502

2021 Work RVU: 0.00
2021 NF PE RVU: 3.35
2021 Fac PE RVU: NA

RUC Recommendation: 0.00 (PE Only) **Referred to CPT** **Result:** PE Only

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0168 **Wound closure utilizing tissue adhesive(s) only**

Global: 000 **Issue:** Wound Closure by Adhesive **Screen:** CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 34 **Specialty Developing Recommendation:** ACEP, AAFP **First Identified:** July 2016 **2019 est Medicare Utilization:** 44,921

2021 Work RVU: 0.31
2021 NF PE RVU: 3.20
2021 Fac PE RVU: 0.08

RUC Recommendation: 0.45 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0179 **Physician re-certification for medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 806,300

2021 Work RVU: 0.45
2021 NF PE RVU: 0.70
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0180 **Physician certification for medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period**

Global: XXX **Issue:** Physician Recertification **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 1,169,998

2021 Work RVU: 0.67
2021 NF PE RVU: 0.81
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0181 **Physician supervision of a patient receiving medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** October 2008 **2019 est Medicare Utilization:** 386,948

2021 Work RVU: 1.73
2021 NF PE RVU: 1.21
2021 Fac PE RVU: NA

RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0182 **Physician supervision of a patient under a medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more**

Global: XXX **Issue:** Home Healthcare Supervision **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 26,148

2021 Work RVU: 1.73
2021 NF PE RVU: 1.25
2021 Fac PE RVU: NA

RUC Recommendation: Recommend deletion after review of 99375 and 99378. No specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0202 **Screening mammography, bilateral (2-view study of each breast), including computer-aided detection (cad) when performed**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Assume CMS will delete **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0204 **Diagnostic mammography, including computer-aided detection (cad) when performed; bilateral**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Assume CMS will delete **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0206 **Diagnostic mammography, including computer-aided detection (cad) when performed; unilateral**

Global: **Issue:** Mammography **Screen:** CMS Fastest Growing / CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: January 2016 **Tab:** 20 **Specialty Developing Recommendation:** ACR **First Identified:** February 2008 **2019 est Medicare Utilization:**

2021 Work RVU:

2021 NF PE RVU:

2021 Fac PE RVU:

RUC Recommendation: Assume CMS will delete **Referred to CPT** October 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0237 **Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)**

Global: XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 40,969

2021 Work RVU: 0.00
2021 NF PE RVU: 0.27
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0238 **Therapeutic procedures to improve respiratory function, other than described by g0237, one on one, face to face, per 15 minutes (includes monitoring)**

Global: XXX **Issue:** Respiratory Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: February 2009 **Tab:** 38 **Specialty Developing Recommendation:** ACCP/ATS **First Identified:** February 2008 **2019 est Medicare Utilization:** 49,322

2021 Work RVU: 0.00
2021 NF PE RVU: 0.28
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen - RUC articulated concerns regarding claims reporting to CMS

Referred to CPT

Result: Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0248 **Demonstration, prior to initiation of home inr monitoring, for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria, under the direction of a physician; includes: face-to-face demonstration of use and care of the inr monitor, obtaining at least one blood sample, provision of instructions for reporting home inr test results, and documentation of patient's ability to perform testing and report results**

Global: XXX **Issue:** Home INR Monitoring **Screen:** High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** January 2016 **2019 est Medicare Utilization:** 23,312

2021 Work RVU: 0.00
2021 NF PE RVU: 1.87
2021 Fac PE RVU: NA

RUC Recommendation: Created Category I code, recommend CMS delete G code

Referred to CPT September 2016

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0249 **Provision of test materials and equipment for home inr monitoring of patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; includes: provision of materials for use in the home and reporting of test results to physician; testing not occurring more frequently than once a week; testing materials, billing units of service include 4 tests**

Global: XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 1,211,835

2021 Work RVU: 0.00
2021 NF PE RVU: 1.69
2021 Fac PE RVU: NA

RUC Recommendation: Created Category I code, recommend CMS delete G code

Referred to CPT September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0250 **Physician review, interpretation, and patient management of home inr testing for patient with either mechanical heart valve(s), chronic atrial fibrillation, or venous thromboembolism who meets medicare coverage criteria; testing not occurring more frequently than once a week; billing units of service include 4 tests**

Global: XXX **Issue:** Home INR Monitoring **Screen:** CMS Fastest Growing / High Volume Growth3 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 19 **Specialty Developing Recommendation:** ACC **First Identified:** February 2008 **2019 est Medicare Utilization:** 185,069

2021 Work RVU: 0.18
2021 NF PE RVU: 0.04
2021 Fac PE RVU: NA

RUC Recommendation: Created Category I code, recommend CMS delete G code

Referred to CPT September 2016 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0268 **Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing**

Global: 000 **Issue:** Removal of Impacted Cerumen **Screen:** CMS Fastest Growing / CMS 000-Day Global Typically Reported with an E/M **Complete?** Yes

Most Recent RUC Meeting: April 2017 **Tab:** 35 **Specialty Developing Recommendation:** AAO-HNS **First Identified:** October 2008 **2019 est Medicare Utilization:** 166,164

2021 Work RVU: 0.61
2021 NF PE RVU: 0.79
2021 Fac PE RVU: 0.27

RUC Recommendation: 0.61

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0270 **Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes**

Global: XXX **Issue:** Medical Nutrition Therapy **Screen:** CMS Fastest Growing **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** ADA **First Identified:** February 2008 **2019 est Medicare Utilization:** 81,177

2021 Work RVU: 0.45
2021 NF PE RVU: 0.46
2021 Fac PE RVU: 0.34

RUC Recommendation: Maintain/Remove from screen **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0279 **Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to 77065 or 77066)**

Global: ZZZ **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** **First Identified:** October 2017 **2019 est Medicare Utilization:** 783,467

2021 Work RVU: 0.60
2021 NF PE RVU: 0.95
2021 Fac PE RVU: NA

RUC Recommendation: Recommend CMS delete **Referred to CPT** **Result:** Remove from Screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0283 **Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care**

Global: XXX **Issue:** Physical Medicine and Rehabilitation Services - Electrical Stimulation Other than Wound **Screen:** Low Value-High Volume / CMS-Other - Utilization over 250,000 / CMS High Expenditure Procedural Codes2 **Complete?** Yes

Most Recent RUC Meeting: January 2017 **Tab:** 29 **Specialty Developing Recommendation:** APTA **First Identified:** October 2010 **2019 est Medicare Utilization:** 7,523,149

2021 Work RVU: 0.18
2021 NF PE RVU: 0.19
2021 Fac PE RVU: NA

RUC Recommendation: 0.18 **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0296 **Counseling visit to discuss need for lung cancer screening using low dose ct scan (ldct) (service is for eligibility determination and shared decision making)**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** No

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: January 2019

2019 est Medicare Utilization: 50,164

2021 Work RVU: 0.52
2021 NF PE RVU: 0.27
2021 Fac PE RVU: 0.20

RUC Recommendation: Submit action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G0297 **Low dose ct scan (ldct) for lung cancer screening**

Global: **Issue:** Screening CT of Thorax **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 07 **Specialty Developing Recommendation:**

First Identified: October 2018

2019 est Medicare Utilization: 260,400

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Recommend CMS delete. Cat I code created.

Referred to CPT May 2019
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

G0364 **Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:**

First Identified: October 2017

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Deleted from CPT

Status Report: CMS Requests and Relativity Assessment Issues

G0365 **Vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)**

Global: **Issue:** Duplex Scan Arterial Inflow-Venous Outflow Upper Extremity **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 17 **Specialty Developing Recommendation:** ACR, SIR, SVS **First Identified:** October 2017 **2019 est Medicare Utilization:** 38,289

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** September 2018 **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0389 **Ultrasound b-scan and/or real time with image documentation; for abdominal aortic aneurysm (aaa) screening**

Global: **Issue:** Abdominal Aorta Ultrasound Screening **Screen:** Final Rule for 2015 / High Volume Growth4 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 12 **Specialty Developing Recommendation:** ACC, ACP, ACR, SCAI, SVS **First Identified:** July 2014 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: CPT Assistant article published **Referred to CPT** May 2015 **Result:** Deleted from CPT

Referred to CPT Asst ☑ **Published in CPT Asst:** Jan 2017

G0396 **Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** No

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:** AAFP, ASA, ASAM **First Identified:** October 2017 **2019 est Medicare Utilization:** 51,068

2021 Work RVU: 0.65
2021 NF PE RVU: 0.34
2021 Fac PE RVU: 0.25

RUC Recommendation: Refer to CPT **Referred to CPT** Time Uncertain **Result:**

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0399 **Home sleep test (hst) with type iii portable monitor, unattended; minimum of 4 channels: 2 respiratory movement/airflow, 1 ecg/heart rate and 1 oxygen saturation**

Global: XXX **Issue:** **Screen:** High Volume Growth5 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 112,455

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: NA

RUC Recommendation: CMS delete **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0402 **Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of medicare enrollment**

Global: XXX **Issue:** Initial Preventive Exam **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 526,509

2021 Work RVU: 2.60
2021 NF PE RVU: 2.11
2021 Fac PE RVU: 1.14

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0403 **Electrocardiogram, routine ecg with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report**

Global: XXX **Issue:** EKG for Initial Preventive Exam **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 129,413

2021 Work RVU: 0.17
2021 NF PE RVU: 0.24
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0407 **Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ANA, APA (psychiatry) **First Identified:** October 2020 **2019 est Medicare Utilization:** 54,207

2021 Work RVU: 1.39
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.57

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0408 **Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: April 2021 **Tab:** 24 **Specialty Developing Recommendation:** AAN, ANA, APA (psychiatry) **First Identified:** October 2020 **2019 est Medicare Utilization:** 28,734

2021 Work RVU: 2.00
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.82

RUC Recommendation: Review action plan **Referred to CPT** **Result:**
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0416 **Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method**

Global: XXX **Issue:** Prostate Biopsy - Pathology **Screen:** Final Rule for 2015 **Complete?** Yes

Most Recent RUC Meeting: October 2015 **Tab:** 16 **Specialty Developing Recommendation:** ASC, CAP **First Identified:** July 2014 **2019 est Medicare Utilization:** 133,021

2021 Work RVU: 3.60
2021 NF PE RVU: 6.46
2021 Fac PE RVU: NA

RUC Recommendation: 4.00 **Referred to CPT** **Result:** Increase
Referred to CPT Asst ☐ **Published in CPT Asst:**

G0422 **Intensive cardiac rehabilitation; with or without continuous ecg monitoring with exercise, per session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 29,034

2021 Work RVU: 1.70
2021 NF PE RVU: 1.43
2021 Fac PE RVU: 1.43

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen
Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0423 **Intensive cardiac rehabilitation; with or without continuous ecg monitoring; without exercise, per session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** **First Identified:** October 2020 **2019 est Medicare Utilization:** 45,564

2021 Work RVU: 1.70
2021 NF PE RVU: 1.43
2021 Fac PE RVU: 1.43

RUC Recommendation: Maintain **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0436 **Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than 3 minutes, up to 10 minutes**

Global: **Issue:** RAW **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** **First Identified:** April 2016 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: Deleted from CPT **Referred to CPT** **Result:** Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0438 **Annual wellness visit; includes a personalized prevention plan of service (pps), initial visit**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2013 **2019 est Medicare Utilization:** 1,114,054

2021 Work RVU: 2.60
2021 NF PE RVU: 2.10
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. **Referred to CPT** **Result:** Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0439 **Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 250,000 **Complete?** Yes

Most Recent RUC Meeting: April 2016 **Tab:** 47 **Specialty Developing Recommendation:** No Interest **First Identified:** April 2013 **2019 est Medicare Utilization:** 8,360,475

2021 Work RVU: 1.92
2021 NF PE RVU: 1.78
2021 Fac PE RVU: NA

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0442 **Annual alcohol misuse screening, 15 minutes**

Global: XXX **Issue:** Annual Alcohol Screening **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 893,133

2021 Work RVU: 0.18
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.08

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0444 **Annual depression screening, 15 minutes**

Global: XXX **Issue:** Annual Depression Screening **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 2,127,052

2021 Work RVU: 0.18
2021 NF PE RVU: 0.35
2021 Fac PE RVU: 0.08

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT

Result: Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0446 **Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes**

Global: XXX **Issue:** Intensive Behavioral Therapy for Cardiovascular Disease **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** October 2017 **2019 est Medicare Utilization:** 253,992

2021 Work RVU: 0.45
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.20

RUC Recommendation: Survey, but no specialty interest, so no recommendation.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0447 **Face-to-face behavioral counseling for obesity, 15 minutes**

Global: XXX **Issue:** Behavioral Counseling for Obesity **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:** No Specialty Society Interest **First Identified:** April 2016 **2019 est Medicare Utilization:** 336,973

2021 Work RVU: 0.45
2021 NF PE RVU: 0.28
2021 Fac PE RVU: 0.20

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0452 **Molecular pathology procedure; physician interpretation and report**

Global: XXX **Issue:** Molecular Pathology Interpretation **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 13 **Specialty Developing Recommendation:** **First Identified:** October 2018 **2019 est Medicare Utilization:** 128,942

2021 Work RVU: 0.93
2021 NF PE RVU: 0.44
2021 Fac PE RVU: NA

RUC Recommendation: 0.93

Referred to CPT **Result:** Increase

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0453 **Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure)**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 100,000 **Complete?** Yes

Most Recent RUC Meeting: October 2016 **Tab:** 35 **Specialty Developing Recommendation:**

First Identified: April 2016

2019 est Medicare Utilization: 402,739

2021 Work RVU: 0.60
2021 NF PE RVU: NA
2021 Fac PE RVU: 0.30

RUC Recommendation: Remove from screen

Referred to CPT

Result: Remove from screen

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0456 **Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area less than or equal to 50 square centimeters**

Global: **Issue:** Negative Pressure Wound Therapy **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: November 2012

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.

Referred to CPT May 2013

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

G0457 **Negative pressure wound therapy, (e.g. vacuum assisted drainage collection) using a mechanically-powered device, not durable medical equipment, including provision of cartridge and dressing(s), topical application(s), wound assessment, and instructions for ongoing care, per session; total wounds(s) surface area greater than 50 square centimeters**

Global: **Issue:** Negative Pressure Wound Therapy **Screen:** CMS Request - Final Rule for 2013 **Complete?** Yes

Most Recent RUC Meeting: January 2014 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: November 2012

2019 est Medicare Utilization:

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: RUC recommended to survey but no specialty society interest followed. CMS deleted.

Referred to CPT May 2013

Result: Deleted from CPT

Referred to CPT Asst ☐ **Published in CPT Asst:**

Status Report: CMS Requests and Relativity Assessment Issues

G0500 **Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time; patient age 5 years or older (additional time may be reported with 99153, as appropriate)**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization: 490,072

2021 Work RVU: 0.10
2021 NF PE RVU: 1.57
2021 Fac PE RVU: 0.04

RUC Recommendation: Maintain

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

G0506 **Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)**

Global: ZZZ **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** Yes

Most Recent RUC Meeting: October 2021 **Tab:** 20 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization: 119,106

2021 Work RVU: 0.87
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.37

RUC Recommendation: Request CMS Delete

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Request CMS Delete

G6001 **Ultrasonic guidance for placement of radiation therapy fields**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:** AADA, ASTRO

First Identified: October 2020

2019 est Medicare Utilization: 124,968

2021 Work RVU: 0.58
2021 NF PE RVU: 3.88
2021 Fac PE RVU: NA

RUC Recommendation: Refer to CPT

Referred to CPT February 2022
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

Status Report: CMS Requests and Relativity Assessment Issues

G6002 **Stereoscopic x-ray guidance for localization of target volume for the delivery of radiation therapy**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: January 2018 **Tab:** 31 **Specialty Developing Recommendation:**

First Identified: October 2017

2019 est Medicare Utilization: 1,291,326

2021 Work RVU: 0.39
2021 NF PE RVU: 1.80
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from screen

G6012 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 6-10 mev**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization: 357,383

2021 Work RVU: 0.00
2021 NF PE RVU: 7.57
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G6013 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 11-19 mev**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020

2019 est Medicare Utilization: 218,027

2021 Work RVU: 0.00
2021 NF PE RVU: 7.59
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

Status Report: CMS Requests and Relativity Assessment Issues

G6014 **Radiation treatment delivery,3 or more separate treatment areas, custom blocking, tangential ports, wedges, rotational beam, compensators, electron beam; 20 mev or greater**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 20,000 Part1 **Complete?** Yes

Most Recent RUC Meeting: October 2019 **Tab:** 17 **Specialty Developing Recommendation:**

First Identified: January 2019 **2019 est Medicare Utilization:** 22,014

2021 Work RVU: 0.00
2021 NF PE RVU: 7.57
2021 Fac PE RVU: NA

RUC Recommendation: Remove from screen

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result: Remove from Screen

G6015 **Intensity modulated treatment delivery, single or multiple fields/arcs,via narrow spatially and temporally modulated beams, binary, dynamic mlc, per treatment session**

Global: XXX **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020 **2019 est Medicare Utilization:** 1,297,349

2021 Work RVU: 0.00
2021 NF PE RVU: 11.01
2021 Fac PE RVU: NA

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

G6017 **Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (eg,3d positional tracking, gating, 3d surface tracking), each fraction of treatment**

Global: YYY **Issue:** **Screen:** CMS-Other - Utilization over 20,000 Part2 **Complete?** No

Most Recent RUC Meeting: January 2021 **Tab:** 29 **Specialty Developing Recommendation:**

First Identified: October 2020 **2019 est Medicare Utilization:** 86,769

2021 Work RVU: 0.00
2021 NF PE RVU: 0.00
2021 Fac PE RVU: 0.00

RUC Recommendation: Review action plan

Referred to CPT
Referred to CPT Asst ☐ **Published in CPT Asst:**

Result:

Status Report: CMS Requests and Relativity Assessment Issues

GPCX1 **Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established)**

Global: **Issue:** Visit Complexity E/M Add-On **Screen:** CMS Request - Final Rule for 2020 **Complete?** Yes

Most Recent RUC Meeting: January 2020 **Tab:** 34 **Specialty Developing Recommendation:**

First Identified: November 2019 **2019 est Medicare Utilization:**

2021 Work RVU:
2021 NF PE RVU:
2021 Fac PE RVU:

RUC Recommendation: No recommendation on physician work, time or PE for this code. CMS estimates of utilization for code GPC1X should be more conservative.

Referred to CPT **Result:** N/A

Referred to CPT Asst ☐ **Published in CPT Asst:**

P3001 **Screening papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician**

Global: XXX **Issue:** Cytopathology Cervical/Vaginal **Screen:** CMS-Other - Utilization over 30,000 **Complete?** Yes

Most Recent RUC Meeting: April 2018 **Tab:** 26 **Specialty Developing Recommendation:** CAP

First Identified: October 2017 **2019 est Medicare Utilization:** 1,599

2021 Work RVU: 0.26
2021 NF PE RVU: 0.36
2021 Fac PE RVU: 0.36

RUC Recommendation: 0.42

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

Q0091 **Screening papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory**

Global: XXX **Issue:** RAW **Screen:** CMS-Other - Utilization over 30,000-Part2 **Complete?** Yes

Most Recent RUC Meeting: January 2019 **Tab:** 37 **Specialty Developing Recommendation:** No Specialty Society Interest

First Identified: October 2018 **2019 est Medicare Utilization:** 533,729

2021 Work RVU: 0.37
2021 NF PE RVU: 0.85
2021 Fac PE RVU: 0.14

RUC Recommendation: RUC recommended to survey but no specialty society interest followed.

Referred to CPT **Result:** Maintain

Referred to CPT Asst ☐ **Published in CPT Asst:**

CPT	2022 Long Descriptor	Issue	Most Recent RUC Meeting Date	Tab	Next RUC Review	RUC or RAW to Review	Specialty Society to Survey	RUC Recommendation	Screen	First Identified - RUC Meeting Date	Global	2021 work RVU	2021 Non-Fac PE RVU	2021 Fac PE RVU	2021 PLI RVU	2019e Medicare Utilization	Referred to CPT Asst	CPT Asst Status	CPT Asst Complete	Referred to CPT	Refer to CPT Background	CPT Meeting	CPT Tab	CPT Ed Panel Status Complete	Complete	Result
00534	Anesthesia for	RAW	January 2019	37			ASA	Remove fr	High Volur	October 2(	XXX		0 0.00	0.00	0.00	30245	FALSE			FALSE					TRUE	Remove from Screen
00537	Anesthesia for	Anesthesia for Cardi	October 2020	13			ASA	12	High Volur	October 2(	XXX		0 0.00	0.00	0.00	89969	FALSE			FALSE					TRUE	Increase
00560	Anesthesia for	RAW	January 2019	37			ASA	Remove fr	High Volur	October 2(	XXX		0 0.00	0.00	0.00	58933	FALSE			FALSE					TRUE	Remove from Screen
00731	Anesthesia for	Anesthesia for Intes	January 2017	04			ASA	5 base uni	CMS Requ	Septembe	XXX		0 0.00	0.00	0.00	1262160	FALSE			FALSE	In September 2016 the CI	Septembe	12	yes	TRUE	Maintain
00732	Anesthesia for	Anesthesia for Intes	January 2017	04			ASA	6 base uni	CMS Requ	Septembe	XXX		0 0.00	0.00	0.00	105226	FALSE			FALSE	In September 2016 the CI	Septembe	12	yes	TRUE	Increase
00740	Anesthesia for	Anesthesia for Intes	January 2017	04			ASA	Deleted fr	CMS Requ	July 2015							FALSE			TRUE	In April 2016, an Ad Hoc A	Septembe	12	yes	TRUE	Deleted from CPT
00810	Anesthesia for	Anesthesia for Intes	January 2017	04			ASA	Deleted fr	CMS Requ	July 2015							FALSE			TRUE	In April 2016, an Ad Hoc A	Septembe	12	yes	TRUE	Deleted from CPT
00811	Anesthesia for	Anesthesia for Intes	April 2017	04			ASA	4 base uni	CMS Requ	Septembe	XXX		0 0.00	0.00	0.00	1186122	FALSE			FALSE	In September 2016 the CI	Septembe	12	yes	TRUE	Decrease
00812	Anesthesia for	Anesthesia for Intes	April 2017	04			ASA	3 base uni	CMS Requ	Septembe	XXX		0 0.00	0.00	0.00	517650	FALSE			FALSE	In September 2016 the CI	Septembe	12	yes	TRUE	Decrease
00813	Anesthesia for	Anesthesia for Intes	January 2017	04			ASA	5 base uni	CMS Requ	Septembe	XXX		0 0.00	0.00	0.00	492977	FALSE			FALSE	In September 2016 the CI	Septembe	12	yes	TRUE	Maintain
00918	Anesthesia for	Anesthesia for trans	January 2021	29				Maintain	High Volur	October 2(	XXX		0 0.00	0.00	0.00	101565	FALSE			FALSE					TRUE	Remove from screen
01916	Anesthesia for	diagnostic arteriogr	October 2020	23	October 2(	RAW		Review ac	High Volur	October 2(	XXX		0 0.00	0.00	0.00	58939	FALSE			FALSE					FALSE	
01930	Anesthesia for	Anesthesia for Inter	February 2008	S			ASA	Remove fr	High Volur	February 2	XXX		0 0.00	0.00	0.00	17980	FALSE			FALSE					TRUE	Remove from Screen
01935	Anesthesia for	Anesthesia Services	January 2021	04			ASA	Deleted fr	High Volur	January 2(	XXX		0 0.00	0.00	0.00	19793	FALSE			FALSE		October 2(	15	complete	TRUE	Deleted from CPT
01936	Anesthesia for	Anesthesia Services	January 2021	04			ASA	Deleted fr	High Volur	October 2(	XXX		0 0.00	0.00	0.00	311884	FALSE			TRUE	This service was identifec	October 2(	15	complete	TRUE	Deleted from CPT
01937	Anesthesia for	Anesthesia Services	January 2021	04			ASA	4	High Volur	January 2021							FALSE			FALSE		October 2(	15	complete	TRUE	Decrease
01938	Anesthesia for	Anesthesia Services	January 2021	04			ASA	4	High Volur	January 2021							FALSE			FALSE		October 2(	15	complete	TRUE	Decrease
01939	Anesthesia for	Anesthesia Services	January 2021	04			ASA	4	High Volur	January 2021							FALSE			FALSE		October 2(	15	complete	TRUE	Decrease
01940	Anesthesia for	Anesthesia Services	January 2021	04			ASA	4	High Volur	January 2021							FALSE			FALSE		October 2(	15	complete	TRUE	Decrease
01941	Anesthesia for	Anesthesia Services	January 2021	04			ASA	6	High Volur	January 2021							FALSE			FALSE		October 2(	15	complete	TRUE	Increase
01942	Anesthesia for	Anesthesia Services	January 2021	04			ASA	6	High Volur	January 2021							FALSE			FALSE		October 2(	15	complete	TRUE	Increase
10004	Fine needle as	Fine Needle Aspirati	October 2017	04				0.80	CMS High	June 2017	ZZZ		0.8 0.59	0.34	0.11	503	FALSE			FALSE					TRUE	Decrease
10005	Fine needle as	Fine Needle Aspirati	January 2020	21				1.63	CMS High	June 2017	XXX		1.46 2.38	0.50	0.15	145323	FALSE			FALSE					TRUE	Decrease
10006	Fine needle as	Fine Needle Aspirati	October 2017	04				1.00	CMS High	June 2017	ZZZ		1 0.67	0.37	0.10	33658	FALSE			FALSE					TRUE	Decrease
10007	Fine needle as	Fine Needle Aspirati	October 2017	04				1.81	CMS High	June 2017	XXX		1.81 7.06	0.67	0.19	395	FALSE			FALSE					TRUE	Decrease
10008	Fine needle as	Fine Needle Aspirati	October 2017	04				1.18	CMS High	June 2017	ZZZ		1.18 3.52	0.41	0.11	32	FALSE			FALSE					TRUE	Decrease
10009	Fine needle as	Fine Needle Aspirati	October 2017	04				2.43	CMS High	June 2017	XXX		2.26 11.44	0.78	0.21	5300	FALSE			FALSE					TRUE	Decrease
10010	Fine needle as	Fine Needle Aspirati	October 2017	04				1.65	CMS High	June 2017	ZZZ		1.65 6.42	0.56	0.15	99	FALSE			FALSE					TRUE	Decrease
10011	Fine needle as	Fine Needle Aspirati	January 2018	04				Contractor	CMS High	June 2017	XXX		0 0.00	0.00	0.00	69	FALSE			FALSE					TRUE	Contractor Price
10012	Fine needle as	Fine Needle Aspirati	January 2018	04				Contractor	CMS High	June 2017	ZZZ		0 0.00	0.00	0.00	21	FALSE			FALSE					TRUE	Contractor Price
10021	Fine needle as	Fine Needle Aspirati	January 2020	21			AACE, ASB	1.20	CMS Requ	July 2015	XXX		1.03 1.85	0.44	0.14	17957	FALSE			TRUE	The specialty societies ga	June 2017	06	yes	TRUE	Decrease
10022	Fine needle as	Fine Needle Aspirati	October 2017	04			AACE, ASB	Deleted fr	CMS Faste	October 2008							FALSE			TRUE	The specialty societies ga	June 2017	06	yes	TRUE	Deleted from CPT
10030	Image-guided	Drainage of Abscess	January 2013	04			ACR, SIR	3.00	Codes Rep	January 2(	000		2.75 16.52	0.94	0.26	8525	FALSE			FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Decrease
10040	Acne surgery (	Acne Surgery	April 2016	13			AAD	0.91	Harvard V	October 2(	010		0.91 2.42	0.52	0.09	41492	FALSE			FALSE					TRUE	Decrease
10060	Incision and dr	Incision and Drainag	October 2010	07			APMA	1.50	Harvard V	February 2	010		1.22 2.27	1.66	0.13	368976	FALSE			FALSE					TRUE	Increase
10061	Incision and dr	Incision and Drainag	January 2020	37			APMA	Maintain.	Harvard V	October 2(	010		2.45 3.45	2.57	0.31	134001	FALSE			FALSE					TRUE	Maintain
10120	Incision and removal of foreign boc		September 201	12			APMA, AA	1.25	Harvard V	April 2011	010		1.22 3.14	1.68	0.14	43240	FALSE			FALSE					TRUE	Maintain
10180	Incision and drainage, complex, pos		October 2013	18				Remove fr	RUC identi	January 2(	010		2.3 4.99	2.44	0.48	9692	FALSE			FALSE					TRUE	Maintain
11040	Deleted from (	Excision and Debrid	September 200	16			APMA, AP	Deleted fr	Site of Ser	September 2007							FALSE			TRUE	Descriptor enables a bi-m	October 2(	15	Code Delete	TRUE	Deleted from CPT
11041	Deleted from (	Excision and Debrid	September 200	16			APMA, AP	Deleted fr	Site of Ser	September 2007							FALSE			TRUE	Descriptor enables a bi-m	October 2(	15	Code Delete	TRUE	Deleted from CPT
11042	Debridement,	Excision and Debrid	February 2010	04			APMA, AP	1.12	Site of Ser	Septembe	000		1.01 2.68	0.62	0.13	1938307	FALSE			TRUE	Descriptor enables a bi-m	October 2(	15	Complete	TRUE	Increase
11043	Debridement,	Debridement	February 2010	04			APMA, AP	3.00	Site of Ser	Septembe	000		2.7 3.78	1.40	0.42	456527	FALSE			TRUE	Descriptor enables a bi-m	October 2(	15	Complete	TRUE	Decrease
11044	Debridement,	Debridement	February 2010	04			APMA, AP	4.56	Site of Ser	Septembe	000		4.1 4.42	1.83	0.64	88567	FALSE			TRUE	Descriptor enables a bi-m	October 2(	15	Complete	TRUE	Increase
11045	Debridement,	Excision and Debrid	February 2010	04			ACS, APM/	0.69	Site of Ser	February 2	ZZZ		0.5 0.62	0.18	0.09	492140	FALSE			FALSE					TRUE	Increase
11046	Debridement,	Debridement	February 2010	04			ACS, APM/	1.29	Site of Ser	February 2	ZZZ		1.03 0.94	0.40	0.20	239254	FALSE			FALSE					TRUE	Decrease
11047	Debridement,	Debridement	January 2020	37			ACS, APM/	2.00	Site of Ser	February 2	ZZZ		1.8 1.44	0.71	0.34	66673	FALSE			FALSE					TRUE	Increase
11055	Paring or cutti	RAW Review	January 2012	30			APMA	Maintain	CMS Requ	November	000		0.35 1.66	0.08	0.04	886591	FALSE			FALSE					TRUE	Maintain
11056	Paring or cutti	Trim Skin Lesions	January 2012	53			APMA	0.50	MPC List /	October 2(	000		0.5 1.81	0.11	0.04	2010288	FALSE			FALSE					TRUE	Decrease
11057	Paring or cutti	RAW Review	January 2012	30			APMA	Maintain	CMS Requ	November	000		0.65 1.88	0.14	0.05	346586	FALSE			FALSE					TRUE	Maintain
11100	Biopsy of skin,	Biopsy of Skin Lesior	April 2017	05			AAD	Deleted fr	MPC List /	October 2010							FALSE			TRUE	Prior to the January 2016	February 2	65	yes	TRUE	Deleted from CPT
11101	Biopsy of skin,	Biopsy of Skin Lesior	April 2017	05			AAD	Deleted fr	Low Value	October 2010							FALSE			TRUE	Prior to the January 2016	February 2	65	yes	TRUE	Deleted from CPT
11102	Tangential bio	Skin Biopsy	April 2017	05				0.66	CMS High	February 2	000		0.66 2.34	0.38	0.05	3333585	FALSE			FALSE		February 2	65	yes	TRUE	Decrease
11103	Tangential bio	Skin Biopsy	April 2017	05				0.38	CMS High	February 2	ZZZ		0.38 1.13	0.22	0.04	1456282	FALSE			FALSE		February 2	65	yes	TRUE	Decrease
11104	Punch biopsy (	Skin Biopsy	April 2017	05				0.83	CMS High	February 2	000		0.83 2.90	0.46	0.09	388339	FALSE			FALSE		February 2	65	yes	TRUE	Decrease
11105	Punch biopsy (	Skin Biopsy	April 2017	05				0.45	CMS High	February 2	ZZZ		0.45 1.29	0.25	0.05	97094	FALSE			FALSE		February 2	65	yes	TRUE	Decrease
11106	Incisional biop	Skin Biopsy	April 2017	05				1.01	CMS High	February 2	000		1.01 3.55	0.56	0.11	37327	FALSE			FALSE		February 2	65	yes	TRUE	Decrease
11107	Incisional biop	Skin Biopsy	April 2017	05				0.54	CMS High	February 2	ZZZ		0.54 1.55	0.31	0.05	7020	FALSE			FALSE		February 2	65	yes	TRUE	Decrease
11300	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	0.60	CMS High	January 2(	000		0.6 2.38	0.33	0.05	104786	FALSE			FALSE					TRUE	Increase
11301	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	0.90	CMS High	January 2(	000		0.9 2.67	0.50	0.09	205570	FALSE			FALSE					TRUE	Increase
11302	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	1.16	CMS High	January 2(	000		1.05 3.02	0.59	0.11	114770	FALSE			FALSE					TRUE	Increase
11303	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	1.25	CMS High	January 2(	000		1.25 3.22	0.69	0.13	16712	FALSE			FALSE					TRUE	Increase
11305	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	0.80	CMS High	January 2(	000		0.8 2.32	0.24	0.06	100773	FALSE			FALSE					TRUE	Increase
11306	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	1.18	CMS High	January 2(	000		0.96 2.63	0.39	0.09	102882	FALSE			FALSE					TRUE	Increase
11307	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	1.20	CMS High	January 2(	000		1.2 2.95	0.54	0.11	51111	FALSE			FALSE					TRUE	Increase
11308	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	1.46	CMS High	January 2(	000		1.46 2.93	0.51	0.13	14010	FALSE			FALSE					TRUE	Increase
11310	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	1.19	CMS High	January 2(	000		0.8 2.60	0.44	0.09	74188	FALSE			FALSE					TRUE	Increase
11311	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	1.43	CMS High	January 2(	000		1.1 2.89	0.61	0.13	100460	FALSE			FALSE					TRUE	Increase
11312	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	1.80	CMS High	January 2(	000		1.3 3.26	0.73	0.14	46378	FALSE			FALSE					TRUE	Increase
11313	Shaving of epic	Shaving of Epiderma	April 2012	38			AAD	2.00	CMS High	January 2(	000		1.68 3.60	0.94	0.17	8180	FALSE			FALSE					TRUE	Increase
11719	Trimming of n	Debridement of Nail	January 2012	32			APMA	0.17	Low Value	October 2(	000		0.17 0.23	0.04	0.01	837707	FALSE			FALSE					TRUE	Maintain
11720	Debridement (	Debridement of Nail	September 201	53			APMA	0.32 (Inter	MPC List	Septemer	000		0.32 0.61	0.07	0.04	2111275	FALSE			FALSE					TRUE	Maintain
11721	Debridement (	Debridement of Nail	September 201	53			APMA	0.54 (Inter	MPC List	October 2(	000		0.54 0.72	0.12	0.04	6784854	FALSE			FALSE					TRUE	Maintain
11730	Avulsion of nai	Removal of Nail Plat	January 2016	56			APMA	1.10	CMS High	July 2015	000		1.05 2.29	0.43	0.09	378522	FALSE			FALSE					TRUE	Maintain
11750	Excision of nail	Excision of Nail Bed	September 201	26		RUC Review work an		1.99	010-Day G	January 2(	010		1.58 3.06	1.25	0.13	201719	FALSE			FALSE					TRUE	Decrease
11752	Excision of nail	Excision of Nail Bed	January 2015	28				Deleted fr	010-Day G	January 2014							FALSE			TRUE	The American Podiatric M	October 2(	09	Code Delete	TRUE	Deleted from CPT

11755	Biopsy of nail ı	Biopsy of Nail	April 2017	41i	APMA	1.25	CMS 000-[	July 2016	000	1.25	2.38	0.43	0.10	62237	FALSE		FALSE						TRUE	Decrease
11900	Injection, intra	Skin Injection Servic	April 2010	31	AAD	0.52	Harvard V:	October 2(	000	0.52	1.08	0.30	0.05	265694	FALSE		FALSE						TRUE	Maintain
11901	Injection, intra	Skin Injection Servic	April 2010	31	AAD	0.80	Harvard V:	February 2	000	0.8	1.17	0.46	0.09	73970	FALSE		FALSE						TRUE	Maintain
11980	Subcutaneous	Drug Delivery Impla	October 2018	05	AAOS, ACC	1.10	High Volur	April 2013	000	1.1	1.54	0.39	0.14	33888	FALSE		TRUE	In January 2018, this serv	May 2018	10	Yes		TRUE	Decrease
11981	Insertion, drug	Drug Delivery Impla	October 2018	05	AAOS, ACC	1.30	High Volur	June 2008	000	1.14	1.70	0.52	0.21	13060	FALSE		TRUE	In January 2018, this serv	May 2018	10	Yes		TRUE	Decrease
11982	Removal, non-	Drug Delivery Impla	October 2018	05	AAOS, ACC	1.70	High Volur	February 2	000	1.34	1.85	0.61	0.25	4500	FALSE		TRUE	In January 2018, this serv	May 2018	10	Yes		TRUE	Decrease
11983	Removal with ı	Drug Delivery Impla	October 2018	05	AAOS, ACC	2.10	High Volur	June 2008	000	1.91	2.03	0.81	0.32	2345	FALSE		FALSE						TRUE	Decrease
12001	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	0.84	Harvard V:	October 2(	000	0.84	1.77	0.31	0.15	184284	FALSE		FALSE						TRUE	Decrease
12002	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	1.14	Harvard V:	October 2(	000	1.14	1.99	0.37	0.21	142967	FALSE		FALSE						TRUE	Decrease
12004	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	1.44	Harvard V:	April 2010	000	1.44	2.18	0.44	0.26	22345	FALSE		FALSE						TRUE	Decrease
12005	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	1.97	Harvard V:	April 2010	000	1.97	2.84	0.46	0.38	6059	FALSE		FALSE						TRUE	Decrease
12006	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	2.39	Harvard V:	April 2010	000	2.39	3.22	0.59	0.45	1137	FALSE		FALSE						TRUE	Decrease
12007	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	2.90	Harvard V:	April 2010	000	2.9	3.42	0.81	0.58	357	FALSE		FALSE						TRUE	Decrease
12011	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	1.07	Harvard V:	April 2010	000	1.07	2.06	0.35	0.21	90553	FALSE		FALSE						TRUE	Decrease
12013	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	1.22	Harvard V:	April 2010	000	1.22	2.02	0.26	0.23	50435	FALSE		FALSE						TRUE	Decrease
12014	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	1.57	Harvard V:	April 2010	000	1.57	2.37	0.33	0.30	6842	FALSE		FALSE						TRUE	Decrease
12015	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	1.98	Harvard V:	April 2010	000	1.98	2.74	0.42	0.38	3321	FALSE		FALSE						TRUE	Decrease
12016	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	2.68	Harvard V:	April 2010	000	2.68	3.30	0.59	0.51	526	FALSE		FALSE						TRUE	Decrease
12017	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	3.18	Harvard V:	April 2010	000	3.18	NA	0.67	0.64	72	FALSE		FALSE						TRUE	Decrease
12018	Simple repair (	Repair of Superficial	April 2010	32	ACEP, AAF	3.61	Harvard V:	April 2010	000	3.61	NA	0.74	0.74	17	FALSE		FALSE						TRUE	Decrease
12031	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	2.00	Harvard V:	February 2	010	2	5.54	2.15	0.25	63049	FALSE		FALSE						TRUE	Decrease
12032	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	2.52	Harvard V:	October 2(	010	2.52	6.28	2.71	0.26	280457	FALSE		FALSE						TRUE	Maintain
12034	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	2.97	Harvard V:	February 2	010	2.97	6.53	2.60	0.41	25707	FALSE		FALSE						TRUE	Maintain
12035	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	3.60	Harvard V:	February 2	010	3.5	7.58	2.92	0.64	4889	FALSE		FALSE						TRUE	Increase
12036	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	4.50	Harvard V:	February 2	010	4.23	7.86	3.22	0.84	1073	FALSE		FALSE						TRUE	Increase
12037	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	5.25	Harvard V:	February 2	010	5	8.45	3.61	1.02	458	FALSE		FALSE						TRUE	Increase
12041	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	2.10	Harvard V:	February 2	010	2.1	5.46	1.86	0.26	20831	FALSE		FALSE						TRUE	Decrease
12042	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	2.79	Harvard V:	February 2	010	2.79	6.05	2.58	0.31	52449	FALSE		FALSE						TRUE	Maintain
12044	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	3.19	Harvard V:	February 2	010	3.19	7.68	2.57	0.45	2304	FALSE		FALSE						TRUE	Maintain
12045	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	3.90	Harvard V:	February 2	010	3.75	7.69	3.48	0.64	337	FALSE		FALSE						TRUE	Increase
12046	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	4.60	Harvard V:	February 2	010	4.3	9.67	3.99	1.04	89	FALSE		FALSE						TRUE	Increase
12047	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	5.50	Harvard V:	February 2	010	4.95	10.26	4.23	1.21	50	FALSE		FALSE						TRUE	Increase
12051	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	2.33	Harvard V:	February 2	010	2.33	5.76	2.29	0.28	54376	FALSE		FALSE						TRUE	Decrease
12052	Repair, interm	Repair of Intermedi	April 2010	45	AAO-HNS,	Remove fr	Harvard V:	February 2	010	2.87	6.10	2.58	0.34	75683	FALSE		FALSE						TRUE	Remove from Screen
12053	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	3.17	Harvard V:	February 2	010	3.17	7.28	2.66	0.43	9218	FALSE		FALSE						TRUE	Maintain
12054	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	3.50	Harvard V:	February 2	010	3.5	7.45	2.32	0.54	2576	FALSE		FALSE						TRUE	Maintain
12055	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	4.65	Harvard V:	February 2	010	4.5	9.72	3.43	0.79	281	FALSE		FALSE						TRUE	Increase
12056	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	5.50	Harvard V:	February 2	010	5.3	11.05	5.03	0.94	41	FALSE		FALSE						TRUE	Increase
12057	Repair, interm	Repair of Intermedi	October 2010	22	AAO-HNS,	6.28	Harvard V:	February 2	010	6	11.25	5.28	1.07	25	FALSE		FALSE						TRUE	Increase
13100	Repair, compl	Complex Wound Re	April 2012	37	AAD, AAO-	3.00	CMS Requ	July 2011	010	3	6.88	2.49	0.36	6433	FALSE		FALSE						TRUE	Decrease
13101	Repair, compl	Complex Wound Re	April 2012	37	AAD, AAO-	3.50	CMS Requ	July 2011	010	3.5	8.05	3.38	0.39	102897	FALSE		FALSE						TRUE	Decrease
13102	Repair, compl	Complex Wound Re	April 2012	37	AAD, AAO-	1.24	CMS Requ	July 2011	ZZZ	1.24	2.09	0.68	0.19	26791	FALSE		FALSE						TRUE	Maintain
13120	Repair, compl	Complex Wound Re	October 2017	19	AAD, AAO-	3.23	CMS Faste	October 2(	010	3.23	7.04	3.22	0.37	12693	TRUE	1st article: complete	FALSE		Septembe	9	Complete		TRUE	Decrease
13121	Repair, compl	Complex Wound Re	October 2017	19	AAD, AAO-	4.00	CMS Faste	October 2(	010	4	8.34	3.08	0.43	207941	TRUE	1st article: complete	FALSE		Septembe	9	Complete		TRUE	Decrease
13122	Repair, compl	Complex Wound Re	October 2017	19	AAD, AAO-	1.44	CMS Faste	October 2(	ZZZ	1.44	2.18	0.78	0.20	31342	TRUE	1st article: complete	FALSE		Septembe	9	Complete		TRUE	Maintain
13131	Repair, compl	Complex Wound Re	April 2012	37	AAD, AAO-	3.73	Harvard V:	April 2011	010	3.73	7.46	2.90	0.43	41454	FALSE		FALSE						TRUE	Decrease
13132	Repair, compl	Complex Wound Re	April 2012	37	AAD, AAO-	4.78	CMS Requ	Septembe	010	4.78	8.81	3.52	0.49	309273	FALSE		FALSE						TRUE	Decrease
13133	Repair, compl	Complex Wound Re	April 2012	37	AAD, AAO-	2.19	CMS Requ	Septembe	ZZZ	2.19	2.58	1.22	0.26	17262	FALSE		FALSE						TRUE	Maintain
13150	Repair, compl	Complex Wound Re	April 2012	37	AAD, AAO-	Deleted fr	CMS Requ	September 2011							FALSE		TRUE	Specialties are requesting	October 2(	05	Deleted fro		TRUE	Deleted from CPT
13151	Repair, compl	Complex Wound Re	April 2012	37	AAD, AAO-	4.34	CMS Requ	Septembe	010	4.34	7.79	3.26	0.51	33842	FALSE		FALSE						TRUE	Decrease
13152	Repair, compl	Complex Wound Re	April 2012	37	AAD, AAO-	5.34	Harvard V:	April 2011	010	5.34	8.93	3.83	0.61	54926	FALSE		FALSE						TRUE	Decrease
13153	Repair, compl	Complex Wound Re	April 2012	37	AAD, AAO-	2.38	CMS Requ	July 2011	ZZZ	2.38	2.80	1.28	0.34	938	FALSE		FALSE						TRUE	Maintain
14000	Adjacent tissu	Skin Tissue Rearran	October 2008	9	ACS, AAD,	6.19	Site of Ser	April 2008	090	6.37	11.17	7.16	1.03	7303	FALSE		FALSE						TRUE	Decrease
14001	Adjacent tissu	Skin Tissue Rearran	October 2008	9	ACS, AAD,	8.58	Site of Ser	Septembe	090	8.78	13.39	8.68	1.49	9637	FALSE		FALSE						TRUE	Decrease
14020	Adjacent tissu	Skin Tissue Rearran	October 2008	9	AAD, ASPS	7.02	Site of Ser	April 2008	090	7.22	12.29	8.16	0.97	17817	FALSE		FALSE						TRUE	Decrease
14021	Adjacent tissu	Skin Tissue Rearran	October 2008	9	AAD, ASPS	9.52	Site of Ser	Septembe	090	9.72	14.29	9.54	1.25	19350	FALSE		FALSE						TRUE	Decrease
14040	Adjacent tissu	Skin Tissue Rearran	October 2008	9	AAD, ASPS	8.44	Site of Ser	April 2008	090	8.6	12.51	8.42	1.03	67406	FALSE		FALSE						TRUE	Maintain
14041	Adjacent tissu	Skin Tissue Rearran	October 2008	9	AAD, ASPS	10.63	Site of Ser	Septembe	090	10.83	14.84	9.98	1.25	45011	FALSE		FALSE						TRUE	Decrease
14060	Adjacent tissu	Skin Tissue Rearran	October 2008	9	AAD, ASPS	Maintain	Site of Ser	April 2008	090	9.23	12.12	8.93	1.04	90113	FALSE		FALSE						TRUE	Maintain
14061	Adjacent tissu	Skin Tissue Rearran	October 2008	9	AAD, ASPS	11.25	Site of Ser	Septembe	090	11.48	16.18	10.86	1.34	31224	FALSE		FALSE						TRUE	Decrease
14300	Deleted from (	Adjacent Tissue Trar	April 2009	04	ACS, AAD,	Deleted fr	Site of Ser	September 2007							FALSE		TRUE	The specialty society com	February 2(	09	Code Delete		TRUE	Deleted from CPT
14301	Adjacent tissu	Adjacent Tissue Trar	April 2009	04	ACS, AAO-	12.47	Site of Ser	Septembe	090	12.65	17.28	10.74	1.90	38864	FALSE		FALSE		February 2(	09			TRUE	Decrease
14302	Adjacent tissu	Adjacent Tissue Trar	April 2009	04	ACS, AAO-	3.73	Site of Ser	Septembe	ZZZ	3.73	1.96	1.96	0.64	40086	FALSE		FALSE		February 2(	09			TRUE	Decrease
15002	Surgical prepa	RAW	September 201	21	ASPS	Maintain v	Pre-Time /	January 2(	000	3.65	6.16	2.17	0.64	24066	FALSE		FALSE						TRUE	Maintain
15004	Surgical prepa	RAW	September 201	21	ASPS, APN	Maintain v	Pre-Time /	January 2(	000	4.58	6.61	2.44	0.64	32464	FALSE		FALSE						TRUE	Maintain
15100	Split-thickness	RAW	September 201	21	ASPS	Maintain v	Pre-Time /	January 2(	090	9.9	13.91	9.16	1.88	13549	FALSE		FALSE						TRUE	Maintain
15120	Split-thickness	Autograft	September 200	16	AAO-HNS,	Remove fr	Site of Ser	Septembe	090	10.15	13.24	8.42	1.59	9650	FALSE		FALSE						TRUE	Remove from Screen
15170	Acellular derm	Acellular Dermal Re	February 2010	31	APMA, ASI	Deleted fr	Different F	February 2010							FALSE		FALSE						TRUE	Deleted from CPT
15171	Acellular derm	Acellular Dermal Re	February 2010	31	APMA, ASI	Deleted fr	Different F	February 2010							FALSE		FALSE						TRUE	Deleted from CPT
15175	Acellular derm	Acellular Dermal Re	February 2010	31	APMA, ASI	Deleted fr	Different F	October 2009							FALSE		TRUE	The specialty recommenc	October 2(	07	Complete		TRUE	Deleted from CPT
15176	Acellular derm	Acellular Dermal Re	February 2010	31	APMA, ASI	Deleted fr	Different F	February 2010							FALSE		FALSE						TRUE	Deleted from CPT
15220	Full thickness g	Skin Graft	September 200	16	AAO-HNS,	Reduce 99	Site of Ser	Septembe	090	8.09	13.42	8.53	1.10	9947	FALSE		FALSE						TRUE	PE Only
15240	Full thickness g	RAW	September 201	21	ASPS, AAD	Maintain v	Pre-Time /	January 2(	090	10.41	15.47	11.30	1.35	13328	FALSE		FALSE						TRUE	Maintain
15271	Application of	Chronic Wound Der	April 2011	04	ACS, APM/	1.50	Different F	April 2011	000	1.5	2.83	0.73	0.22	111779	FALSE		FALSE		February 2011				TRUE	Decrease
15272	Application of	Chronic Wound Der	April 2011	04	ACS, APM/	0.59	Different F	April 2011	ZZZ	0.33	0.36	0.12	0.05	14569	FALSE		FALSE		February 2011				TRUE	Decrease
15273	Application of	Chronic Wound Der	April 2011	04	ACS, APM/	3.50	Different F	April 2011	000	3.5	5.22	1.67	0.64	5775	FALSE		FALSE		February 2011				TRUE	Decrease
15274	Application of	Chronic Wound Der	April 2011	04	ACS, APM/	0.80	Different F	April 2011	ZZZ	0.8	1.48	0.36	0.16	25402	FALSE		FALSE		February 2011				TRUE	Decrease
15275	Application of	Chronic Wound Der	April 2011	04	ACS, APM/	1.83	Different F	April 2011	000	1.83	2.68	0.72	0.19	122551	FALSE		FALSE		February 2011				TRUE	Decrease
15276	Application of	Chronic Wound Der	April 2011	04	ACS, APM/	0.59	Different F	April 2011	ZZZ	0.5	0.40	0.17	0.06	6340	FALSE		FALSE		February 2011				TRUE	Decrease
15277	Application of	Chronic Wound Der	April 2011	04	ACS, APM/	4.00	Different F	April 2011	000	4	5.53	1.89	0.70	1720	FALSE		FALSE		February 2011				TRUE	Decrease

15278	Application of	Chronic Wound Der	April 2011	04		ACS, APM/	1.00	Different F	April 2011	ZZZ	1	1.65	0.46	0.20	2936	FALSE			FALSE		February 2011			TRUE	Decrease
15320	Deleted from (	Skin Allograft	February 2010	31		APMA, ASI	Deleted fr	Different F	October 2009							FALSE			TRUE	The specialty recommenc	October 2(	07	Complete	TRUE	Deleted from CPT
15321	Deleted from (	Skin Allograft	February 2010	31		APMA, ASI	Deleted fr	Different F	February 2010							FALSE			FALSE					TRUE	Deleted from CPT
15330	Acellular derm	Allograft	February 2008	S		ASPS	Deleted fr	High IWPL	February 2008							FALSE			FALSE					TRUE	Deleted from CPT
15331	Deleted from (	Acellular Dermal All	February 2010	31		AAO-HNS,	Deleted fr	Different F	February 2010							FALSE			FALSE					TRUE	Deleted from CPT
15335	Deleted from (	Acellular Dermal All	February 2010	31		AAO-HNS,	Deleted fr	Different F	October 2009							FALSE			TRUE	The specialty recommenc	October 2(	07	Complete	TRUE	Deleted from CPT
15336	Deleted from (	Acellular Dermal All	February 2010	31		AAO-HNS,	Deleted fr	Different F	February 2010							FALSE			FALSE		February 2011			TRUE	Deleted from CPT
15360	Deleted from (	Tissue Cultured Allo	February 2010	31		APMA, ASI	Deleted fr	Different F	February 2010							FALSE			FALSE		February 2011			TRUE	Deleted from CPT
15361	Deleted from (	Tissue Cultured Allo	February 2010	31		APMA, ASI	Deleted fr	Different F	February 2010							FALSE			FALSE		February 2011			TRUE	Deleted from CPT
15365	Deleted from (	Tissue Cultured Allo	February 2010	31		APMA, ASI	Deleted fr	Different F	October 2009							FALSE			TRUE	The specialty recommenc	October 2(	07	Complete	TRUE	Deleted from CPT
15366	Deleted from (	Tissue Cultured Allo	February 2010	31		APMA, ASI	Deleted fr	Different F	February 2010							FALSE			FALSE		February 2011			TRUE	Deleted from CPT
15400	Deleted from (	Xenograft	September 200	16		APMA, AA	Deleted fr	Site of Ser	September 2007							FALSE			FALSE					TRUE	Deleted from CPT
15401	Deleted from (	Xenograft	February 2008	S		ACS, ASPS	Deleted fr	High Volur	February 2008							FALSE			FALSE					TRUE	Deleted from CPT
15420	Deleted from (	Xenograft Skin	February 2010	31		APMA, ASI	Deleted fr	Different F	October 2009							FALSE			TRUE	The specialty recommenc	October 2(	07	Complete	TRUE	Deleted from CPT
15421	Deleted from (	Xenograft Skin	February 2010	31		APMA, ASI	Deleted fr	Different F	February 2010							FALSE			FALSE		February 2011			TRUE	Deleted from CPT
15570	Formation of d	Skin Pedicle Flaps	October 2008	10		ACS, ASPS,	10.00	Site of Ser	Septembe	090	10.21	14.85	9.36	1.85	292	FALSE			FALSE					TRUE	Maintain
15572	Formation of d	Skin Pedicle Flaps	October 2008	10		ACS, ASPS,	9.94	Site of Ser	April 2008	090	10.12	14.00	9.64	1.69	691	FALSE			FALSE					TRUE	Maintain
15574	Formation of d	Skin Pedicle Flaps	October 2008	10		ASPS, AAO	10.52	Site of Ser	Septembe	090	10.7	13.68	9.34	1.45	1483	FALSE			FALSE					TRUE	Maintain
15576	Formation of d	Skin Pedicle Flaps	October 2008	10		ASPS, AAO	9.24	Site of Ser	Septembe	090	9.37	12.76	8.61	1.13	4346	FALSE			FALSE					TRUE	Maintain
15730	Midface flap (i	Muscle Flaps	January 2017	05		AAO	13.50	High Level	January 2(	090	13.5	28.61	11.48	1.67	1767	FALSE			FALSE					TRUE	Decrease
15731	Forehead flap	Muscle Flaps	January 2017	05			Not part o	High Level	April 2016	090	14.38	16.41	12.59	2.11	2362	FALSE			TRUE	In April 2016 the RUC revi	Septembe 15		yes	TRUE	Not Part of RAW
15732	Muscle, myoc	Muscle Flaps	January 2017	05		ASPS	Deleted fr	Site of Ser	September 2007							FALSE			TRUE	The specialty society expl	Septembe 15		yes	TRUE	Deleted from CPT
15733	Muscle, myoc	Muscle Flaps	January 2017	05		ASPS	15.68	High Level	January 2(	090	15.68	NA	12.20	2.36	5657	FALSE			FALSE					TRUE	Decrease
15734	Muscle, myoc	Muscle Flaps	April 2016	14			23.00	High Level	October 2(	090	23	NA	16.46	4.72	24232	FALSE			FALSE		Septembe 15		yes	TRUE	Increase
15736	Muscle, myoc	Muscle Flaps	April 2016	14		ASSH, ASP	17.04	High Level	January 2(	090	17.04	NA	15.54	3.20	1501	FALSE			FALSE		Septembe 15		yes	TRUE	Maintain
15738	Muscle, myoc	Muscle Flaps	April 2016	14		ASPS	19.04	High Level	January 2(	090	19.04	NA	15.12	3.52	6218	FALSE			FALSE		Septembe 15		yes	TRUE	Maintain
15740	Flap; island pe	Dermatology and Pl	April 2008	28		AAD, ASPS	11.57	Site of Ser	Septembe	090	11.8	15.93	10.87	1.67	2046	FALSE			TRUE	CPT code 15740 was iden	February 2	11 & 07	Complete	TRUE	Maintain
15769	Grafting of aut	Tissue Grafting Proc	October 2018	04	April 2022 RAW	AAOHNS, /	6.68. Flagg	Site of Ser	May 2018	090	6.68	NA	6.24	1.15		FALSE			FALSE					FALSE	Increase
15771	Grafting of aut	Tissue Grafting Proc	October 2018	04		ASPS	6.73	Site of Ser	May 2018	090	6.73	8.97	6.08	1.15		FALSE			FALSE					TRUE	Increase
15772	Grafting of aut	Tissue Grafting Proc	October 2018	04		ASPS	2.50	Site of Ser	May 2018	ZZZ	2.5	2.34	1.15	0.43		FALSE			FALSE					TRUE	Increase
15773	Grafting of aut	Tissue Grafting Proc	October 2018	04		ASPS	6.83	Site of Ser	May 2018	090	6.83	9.01	6.12	1.15		FALSE			FALSE					TRUE	Increase
15774	Grafting of aut	Tissue Grafting Proc	October 2018	04		ASPS	2.41	Site of Ser	May 2018	ZZZ	2.41	2.30	1.11	0.41		FALSE			FALSE					TRUE	Increase
15777	Implantation o	Chronic Wound Der	April 2011	04		ACS, APM/	3.65	Different F	April 2011	ZZZ	3.65	1.97	1.97	0.68	8429	FALSE			FALSE		February 2011			TRUE	Decrease
15823	Blepharoplast	Upper Eyelid Blepha	April 2010	33		AAO	6.81	Harvard V	October 2(	090	6.81	10.71	8.60	0.59	97994	FALSE			FALSE					TRUE	Decrease
16020	Dressings and/	Dressings/ Debriden	October 2010	08		ASPS, AAF	0.80	Different F	October 2(	000	0.71	1.66	0.77	0.13	15272	FALSE			FALSE					TRUE	Maintain
16025	Dressings and/	Dressings/ Debriden	October 2010	08		ASPS, AAF	1.85	Different F	October 2(	000	1.74	2.58	1.22	0.26	1908	FALSE			FALSE					TRUE	Maintain
16030	Dressings and/	Dressings/ Debriden	April 2010	45		ACEP, ASP	CPT Assist	Different F	February 2	000	2.08	3.28	1.38	0.37	879	TRUE	Oct 2012	Yes	FALSE					TRUE	Maintain
17000	Destruction (e	Destruction of Prem	April 2013	17		AAD	0.61	MPC List	October 2(	010	0.61	1.27	0.90	0.05	6117793	FALSE			FALSE					TRUE	Decrease
17003	Destruction (e	Destruction of Prem	April 2013	17		AAD	0.04	Low Value	October 2(	ZZZ	0.04	0.15	0.02	0.00	19474499	FALSE			FALSE					TRUE	Decrease
17004	Destruction (e	Destruction of Prem	April 2013	17		AAD	Remove fr	CMS High	Septembe	010	1.37	3.35	1.34	0.13	874685	FALSE			FALSE					TRUE	Decrease
17106	Destruction of	Destruction of Skin l	October 2008	11		AAD	3.61	High IWPL	February 2	090	3.69	5.92	3.87	0.39	3933	FALSE			FALSE					TRUE	Decrease
17107	Destruction of	Destruction of Skin l	October 2008	11		AAD	4.68	High IWPL	February 2	090	4.79	7.74	5.00	0.56	1449	FALSE			FALSE					TRUE	Decrease
17108	Destruction of	Destruction of Skin l	October 2008	11		AAD	6.37	High IWPL	February 2	090	7.49	10.10	6.78	0.92	5081	FALSE			FALSE					TRUE	Decrease
17110	Destruction (e	RAW	October 2013	18			Remove fr	High Volur	April 2013	010	0.7	2.57	1.15	0.06	2556286	FALSE			FALSE					TRUE	Remove from Screen
17111	Destruction (e	RAW	October 2013	18			Remove fr	High Volur	April 2013	010	0.97	2.84	1.29	0.09	122909	FALSE			FALSE					TRUE	Remove from screen
17250	Chemical caut	RAW	October 2019	17	January 2(	RAW	AAFP, ACS	Review in	High Volur	October 2(	000	0.5	2.07	0.50	0.06	234080	TRUE	Sep 2016	Yes	TRUE	In January 2016, the Rela	Septembe 17		yes	FALSE	
17261	Destruction, m	Destruction of Malig	October 2010	26		AAD, AAFF	1.22	Harvard V	October 2(	010	1.22	3.00	1.17	0.13	140325	FALSE			FALSE					TRUE	Maintain
17262	Destruction, m	Destruction of Malig	October 2010	26		AAD, AAFF	1.63	Harvard V	February 2	010	1.63	3.45	1.40	0.15	287333	FALSE			FALSE					TRUE	Maintain
17271	Destruction, m	Destruction of Malig	October 2010	26		AAD, AAFF	1.54	Harvard V	February 2	010	1.54	3.18	1.35	0.15	53690	FALSE			FALSE					TRUE	Maintain
17272	Destruction, m	Destruction of Malig	October 2010	26		AAD, AAFF	1.82	Harvard V	February 2	010	1.82	3.54	1.51	0.17	82281	FALSE			FALSE					TRUE	Maintain
17281	Destruction, m	Destruction of Malig	October 2010	26		AAD, AAFF	1.77	Harvard V	February 2	010	1.77	3.33	1.48	0.16	86818	FALSE			FALSE					TRUE	Maintain
17282	Destruction, m	Destruction of Malig	October 2010	26		AAD, AAFF	2.09	Harvard V	October 2(	010	2.09	3.74	1.66	0.21	81831	FALSE			FALSE					TRUE	Maintain
17311	Mohs micrograi	Mohs Surgery	April 2013	18		AAD	6.20	CMS High	Septembe	000	6.2	12.99	3.57	0.59	829586	FALSE			FALSE					TRUE	Maintain
17312	Mohs micrograi	Mohs Surgery	April 2013	18		AAD	3.30	CMS High	Septembe	ZZZ	3.3	8.41	1.89	0.31	509267	FALSE			FALSE					TRUE	Maintain
17313	Mohs micrograi	Mohs Surgery	April 2013	18		AAD	5.56	CMS High	January 2(	000	5.56	12.49	3.20	0.52	140796	FALSE			FALSE					TRUE	Maintain
17314	Mohs micrograi	Mohs Surgery	April 2013	18		AAD	3.06	CMS High	January 2(	ZZZ	3.06	8.16	1.76	0.28	57990	FALSE			FALSE					TRUE	Maintain
17315	Mohs micrograi	Mohs Surgery	April 2013	18		AAD	0.87	CMS High	January 2(	ZZZ	0.87	1.30	0.50	0.09	19946	FALSE			FALSE					TRUE	Maintain
19020	Mastotomy wi	Mastotomy	September 200	16		ACS	Reduce 99	Site of Ser	Septembe	090	3.83	9.57	4.50	0.86	1614	FALSE			FALSE					TRUE	PE Only
19081	Biopsy, breast,	Breast Biopsy	April 2013	04		ACR, ACS,	3.29	Codes Rep	January 2(	000	3.29	13.26	1.19	0.32	60561	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19082	Biopsy, breast,	Breast Biopsy	April 2013	04		ACR, ACS,	1.65	Codes Rep	January 2(	ZZZ	1.65	11.70	0.60	0.16	4476	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19083	Biopsy, breast,	Breast Biopsy	April 2013	04		ACR, ACS,	3.10	Codes Rep	January 2(	000	3.1	13.47	1.12	0.32	118588	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19084	Biopsy, breast,	Breast Biopsy	April 2013	04		ACR, ACS,	1.55	Codes Rep	January 2(	ZZZ	1.55	11.57	0.56	0.15	15269	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19085	Biopsy, breast,	Breast Biopsy	April 2013	04		ACR, ACS,	3.64	Codes Rep	January 2(	000	3.64	22.01	1.32	0.30	5634	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19086	Biopsy, breast,	Breast Biopsy	April 2013	04		ACR, ACS,	1.82	Codes Rep	January 2(	ZZZ	1.82	18.59	0.66	0.15	1195	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19102	Biopsy of brea	Breast Biopsy	April 2013	04		ACR, ACS,	Deleted fr	Codes Rep	January 2012							FALSE			FALSE		October 2(	08	Complete	TRUE	Deleted from CPT
19103	Biopsy of brea	Breast Biopsy	April 2013	04		ACR, ACS,	Deleted fr	Codes Rep	January 2012							FALSE			FALSE		October 2(	08	Complete	TRUE	Deleted from CPT
19281	Placement of t	Breast Biopsy	April 2013	04		ACR, ACS,	2.00	Codes Rep	January 2(	000	2	5.08	0.72	0.16	30514	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19282	Placement of t	Breast Biopsy	April 2013	04		ACR, ACS,	1.00	Codes Rep	January 2(	ZZZ	1	4.08	0.36	0.09	3292	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19283	Placement of t	Breast Biopsy	April 2013	04		ACR, ACS,	2.00	Codes Rep	January 2(	000	2	5.80	0.72	0.20	3526	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19284	Placement of t	Breast Biopsy	April 2013	04		ACR, ACS,	1.00	Codes Rep	January 2(	ZZZ	1	4.98	0.36	0.13	338	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19285	Placement of t	Breast Biopsy	April 2013	04		ACR, ACS,	1.70	Codes Rep	January 2(	000	1.7	10.83	0.62	0.15	25714	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19286	Placement of t	Breast Biopsy	April 2013	04		ACR, ACS,	0.85	Codes Rep	January 2(	ZZZ	0.85	9.77	0.31	0.09	2002	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19287	Placement of t	Breast Biopsy	April 2013	04		ACR, ACS,	3.02	Codes Rep	January 2(	000	2.55	19.02	0.92	0.21	266	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19288	Placement of t	Breast Biopsy	April 2013	04		ACR, ACS,	1.51	Codes Rep	January 2(	ZZZ	1.28	15.82	0.46	0.11	60	FALSE			FALSE		October 2(	08	Complete	TRUE	Decrease
19290	Preoperative p	Breast Biopsy	April 2013	04		ACR, ACS,	Deleted fr	Codes Rep	January 2012							FALSE			FALSE		October 2(	08	Complete	TRUE	Deleted from CPT
19291	Preoperative p	Breast Biopsy	April 2013	04		ACR, ACS,	Deleted fr	Codes Rep	January 2012							FALSE			FALSE		October 2(	08	Complete	TRUE	Deleted from CPT
19295	Image guided p	Breast Biopsy	April 2013	04		ACR, ACS,	Deleted fr	CMS Faste	October 2008							FALSE			FALSE		October 2(	08	Complete	TRUE	Deleted from CPT
19303	Mastectomy, s	Mastectomy	April 2016	15		ACS, ASBS	15.00	Site of Ser	October 2(	090	15	NA	9.73	3.60	24587	FALSE			FALSE					TRUE	Decrease
19307	Mastectomy, r	Modified Radical Ma	January 2020	22			17.99	Site of Ser	October 2(	090	17.99	NA	12.69	4.33	6042	FALSE			FALSE					TRUE	Decrease
19318	Breast reducti	Mammaplasty	September 200	16		ASPS	Reduce 99	Site of Ser	Septembe	090	16.03	NA	13.22	2.89	7501	FALSE			FALSE					TRUE	PE Only

19340	Insertion of br	Breast Implant/Expa	January 2020	05			ASPS	11.00	CMS Requ	October 2(	090	10.48	NA	9.81	1.94	7433	FALSE			FALSE						TRUE	Decrease		
19357	Tissue expand	Breast Implant/Expa	January 2020	05			ASPS	15.36	Site of Ser	Septembe	090	14.84	NA	16.67	2.69	6479	FALSE			TRUE	Originally referred to CPT	October 2(	20	Complete		TRUE	Decrease		
20000	Deleted from (	Incision of Abcess	September 200	16			APMA, AA	Deleted fr	Site of Ser	September 2007							FALSE			TRUE	This service was identifie	June 2009	15	Code Delete		TRUE	Deleted from CPT		
20005	Incision and dr	Incision of Deep Abs	October 2017	19			ACS, AAO-	Deleted fr	Site of Ser	September 2007							FALSE			TRUE	A RUC member requeste	February 2	06	complete		TRUE	Deleted from CPT		
20220	Biopsy, bone, t	Bone Biopsy Trocar/	January 2019	22			ACR, SIR	1.93	Different F	January 2(	000	1.65	5.58	0.75	0.15	12355	FALSE			FALSE						TRUE	Increase		
20225	Biopsy, bone, t	Bone Biopsy Trocar/	January 2019	22			ACR, SIR	3.00	Different F	October 2(	000	2.45	9.49	1.11	0.22	14341	FALSE			FALSE						TRUE	Increase		
20240	Biopsy, bone, (	Bone Biopsy Excisior	January 2016	04			AAOS, APN	3.73	010-Day G	April 2014	000	2.61	NA	1.25	0.31	6533	FALSE			FALSE						TRUE	Increase		
20245	Biopsy, bone, (	Bone Biopsy Excisior	January 2016	04			AAOS	6.50	010-Day G	January 2(	000	6	NA	3.17	1.02	4354	FALSE			TRUE	In April 2015, in preparati	October 2015		revised		TRUE	Decrease		
20525	Removal of for	Removal of Foreign	September 200	16			ACS, AAOS	Reduce 99	Site of Ser	Septembe	010	3.54	10.08	3.09	0.63	1693	FALSE			FALSE						TRUE	PE Only		
20526	Injection, ther	RAW	January 2017	30				Remove fr	CMS 000-D	July 2016	000	0.94	1.27	0.57	0.16	102673	FALSE			FALSE						TRUE	Remove from Screen		
20550	Injection(s); sir	Injection of Tendon	January 2016	27	RUC		AAOS, AAF	0.75	CMS Faste	October 2(	000	0.75	0.80	0.30	0.09	848059	FALSE			FALSE						TRUE	Maintain		
20551	Injection(s); sir	Therapeutic Injectio	April 2017	10			AAPMR, A	0.75	CMS Faste	October 2(	000	0.75	0.84	0.31	0.09	163234	FALSE			FALSE						TRUE	Maintain		
20552	Injection(s); single or multiple trigg	January 2016	28	RUC		AAPM&R,	0.66	CMS High	July 2015	000	0.66	0.84	0.36	0.09	350677	FALSE			FALSE						TRUE	Maintain		
20553	Injection(s); single or multiple trigg	January 2016	28	RUC		AAPM&R,	0.75	CMS High	July 2015	000	0.75	0.98	0.41	0.09	378100	FALSE			FALSE						TRUE	Maintain		
20600	Arthrocentesis	Arthrocentesis	January 2014	04			AAFP, AAC	0.66 and n	Harvard Vi	February 2	000	0.66	0.77	0.30	0.09	444325	FALSE			TRUE	Ultrasound as an imaging	October 2(	06	Complete		TRUE	Maintain		
20604	Arthrocentesis	Arthrocentesis	January 2014	04			AAFP, AAC	0.89	CMS Requ	July 2013	000	0.89	1.38	0.36	0.10	46354	FALSE			FALSE		October 2(	06			TRUE	Decrease		
20605	Arthrocentesis	Arthrocentesis	January 2014	04			AAFP, AAC	0.68 and n	Harvard Vi	October 2(	000	0.68	0.81	0.32	0.09	466622	FALSE			TRUE	Ultrasound as an imaging	October 2(	06	Complete		TRUE	Maintain		
20606	Arthrocentesis	Arthrocentesis	January 2014	04			AAFP, AAC	1.00	CMS Requ	July 2013	000	1	1.47	0.42	0.13	56334	FALSE			FALSE		October 2(	06			TRUE	Decrease		
20610	Arthrocentesis	Arthrocentesis	January 2014	04			AAFP, AAC	0.79 and n	Harvard Vi	February 2	000	0.79	0.96	0.42	0.13	6722382	FALSE			TRUE	Ultrasound as an imaging	October 2(	06	Complete		TRUE	Maintain		
20611	Arthrocentesis	Arthrocentesis	January 2014	04			AAFP, AAC	1.10	CMS Requ	July 2013	000	1.1	1.65	0.51	0.15	1069935	FALSE			FALSE		October 2(	06			TRUE	Decrease		
20612	Aspiration and	RAW	January 2017	30				Remove fr	CMS 000-D	July 2016	000	0.7	1.06	0.41	0.10	28400	FALSE			FALSE						TRUE	Remove from Screen		
20680	Removal of im	RAW	September 201	21			AAOS, APN	5.96 and a	Pre-Time A	January 2(	090	5.96	11.22	5.36	1.02	55761	FALSE			FALSE						TRUE	Maintain		
20692	Application of	RAW	April 2014	52				Maintain	090-Day G	January 2(	090	16.27	NA	13.87	2.76	3150	FALSE			FALSE						TRUE	Maintain		
20694	Removal, unde	External Fixation	September 200	16			AAOS	Reduce 99	Site of Ser	Septembe	090	4.28	7.72	4.95	0.75	6209	FALSE			FALSE						TRUE	PE Only		
20700	Manual prepar	Drug Delivery Implai	October 2018	05			AAOS, AU/	1.50	Different F	May 2018	ZZZ	1.5	0.68	0.68	0.26		FALSE			FALSE						TRUE	Increase		
20701	Removal of dr	Drug Delivery Implai	October 2018	05			AAOS, AU/	1.13	Different F	May 2018	ZZZ	1.13	0.51	0.51	0.21		FALSE			FALSE						TRUE	Increase		
20702	Manual prepar	Drug Delivery Implai	October 2018	05			AAOS, AU/	2.50	Different F	May 2018	ZZZ	2.5	1.14	1.14	0.45		FALSE			FALSE						TRUE	Increase		
20703	Removal of dr	Drug Delivery Implai	October 2018	05			AAOS, AU/	1.80	Different F	May 2018	ZZZ	1.8	0.82	0.82	0.32		FALSE			FALSE						TRUE	Increase		
20704	Manual prepar	Drug Delivery Implai	October 2018	05			AAOS, AU/	2.60	Different F	May 2018	ZZZ	2.6	1.19	1.19	0.47		FALSE			FALSE						TRUE	Increase		
20705	Removal of dr	Drug Delivery Implai	October 2018	05			AAOS, AU/	2.15	Different F	May 2018	ZZZ	2.15	0.98	0.98	0.39		FALSE			FALSE						TRUE	Increase		
20900	Bone graft, an	Bone Graft Procedur	April 2008	29			AOFAS, AA	3.00	Site of Ser	Septembe	000	3	8.60	1.85	0.51	4436	FALSE			FALSE						TRUE	Decrease		
20902	Bone graft, an	Bone Graft Procedur	April 2008	29			AOFAS, AA	4.58	Site of Ser	April 2008	000	4.58	NA	2.76	0.85	4599	FALSE			FALSE						TRUE	Decrease		
20926	Tissue grafts, c	Tissue Grafting Proc	October 2018	04			AAOS, ASP	Deleted fr	CMS Faste	October 2008						14815	TRUE	Deleted fo	N/A	TRUE	In October 2017, AMA Sta	May 2018	12	Yes		TRUE	Deleted from CPT		
21015	Radical resecti	Radical Resection of	February 2009	6			ACS, AAOS	9.71	Site of Ser	Septembe	090	9.89	NA	9.04	1.66	506	FALSE			TRUE	CPT developed new codir	June 2008	06	New code s		TRUE	Increase		
21025	Excision of bor	Excision of Bone – In	October 2010	61			AAOMS	10.03	Site of Ser	Septembe	090	10.03	12.52	8.55	0.95	3614	FALSE			FALSE						TRUE	Decrease		
21495	Open treatmer	Laryngoplasty	January 2016	09	RUC			Deleted fr	090-Day G	October 2015							FALSE			FALSE						TRUE	Deleted from CPT		
21557	Radical resecti	Radical Resection of	February 2009	6			ACS, AAOS	14.57	Site of Ser	Septembe	090	14.75	NA	10.39	2.91	490	FALSE			TRUE	CPT developed new codir	June 2008	06	New code s		TRUE	Decrease		
21800	Closed treatme	Internal Fixation of F	April 2014	05			STS, ACS	Deleted fr	CMS Requ	July 2013							FALSE			TRUE	Refer to CPT for deletion.	February 2	15	Complete		TRUE	Deleted from CPT		
21805	Open treatmer	Internal Fixation of F	April 2014	05			STS, ACS	Deleted fr	CMS Requ	January 2014							FALSE			TRUE	Referred to CPT for deleti	October 2(	7	Complete		TRUE	Deleted from CPT		
21810	Treatment of r	Internal Fixation of F	April 2014	05			STS, ACS	Deleted fr	CMS Requ	January 2014							FALSE			FALSE		October 2(	07	Complete		TRUE	Deleted from CPT		
21811	Open treatmer	Internal Fixation of F	April 2014	05			STS, ACS	19.55	CMS Requ	January 2(	000	10.79	NA	4.31	2.36	357	FALSE			FALSE		October 2(	07	Complete		TRUE	Decrease		
21812	Open treatmer	Internal Fixation of F	April 2014	05			STS, ACS	25.00	CMS Requ	January 2(	000	13	NA	5.32	2.82	468	FALSE			FALSE		October 2(	07	Complete		TRUE	Decrease		
21813	Open treatmer	Internal Fixation of F	April 2014	05			STS, ACS	35.00	CMS Requ	January 2(	000	17.61	NA	7.08	4.32	62	FALSE			FALSE		October 2(	07	Complete		TRUE	Decrease		
21820	Closed treatme	Internal Fixation of F	April 2016	46			AAOS, ACE	PE Clinical	CMS Requ	January 2(	090	1.36	2.76	2.69	0.26	190	TRUE	Jan 2018	yes	FALSE		October 2(	07	Complete		TRUE	PE Only		
21825	Open treatmer	Internal Fixation of F	April 2014	05			STS, ACS	Unrelated	CMS Requ	January 2(	090	7.76	NA	6.59	1.74	737	FALSE			FALSE		October 2(	07	Complete		TRUE	Remove from screen		
21935	Radical resecti	Radical Resection of	February 2009	6			ACS, AAOS	15.54	Site of Ser	Septembe	090	15.72	NA	11.11	3.42	235	FALSE			TRUE	CPT developed new codir	June 2008	06	New code s		TRUE	Decrease		
22214	Osteotomy of :	RAW	September 201	21			AAOS, NAS	Maintain	CMS Faste	October 2(	090	21.02	NA	17.74	5.74	6695	FALSE			FALSE						TRUE	Maintain		
22305	Closed treatme	Closed treatment of	April 2015	23			AANS/CNS	Deleted fr	CMS Requ	July 2013							FALSE			TRUE	In October 2013, AAOS ar	May 2016	13	Complete		TRUE	Deleted from CPT		
22310	Closed treatme	Closed Treatment Vi	January 2020	23	October 2(	RAW	AANS, AAC	3.45. Flag	Negative I'	April 2017	090	3.45	4.93	4.53	0.74	6942	FALSE			FALSE						FALSE	Decrease		
22510	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	8.15	Codes Rep	April 2014	010	7.9	47.52	3.71	0.97	3686	FALSE			FALSE	Joint Workgroup recomm	February 2	16	Complete		TRUE	Decrease		
22511	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	8.05	Codes Rep	April 2014	010	7.33	47.95	3.58	0.92	4104	FALSE			FALSE		February 2	16	Complete		TRUE	Decrease		
22512	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	4.00	Codes Rep	April 2014	ZZZ	4	19.83	1.42	0.61	2505	FALSE			FALSE		February 2	16	Complete		TRUE	Decrease		
22513	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	8.90	Codes Rep	April 2014	010	8.65	185.14	4.81	1.53	24396	FALSE			FALSE		February 2	16	Complete		TRUE	Decrease		
22514	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	8.24	Codes Rep	April 2014	010	7.99	185.16	4.57	1.44	26776	FALSE			FALSE		February 2	16	Complete		TRUE	Decrease		
22515	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	4.00	Codes Rep	April 2014	ZZZ	4	100.20	1.68	0.74	15688	FALSE			FALSE		February 2	16	Complete		TRUE	Decrease		
22520	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	Deleted fr	CMS Requ	February 2009							FALSE			TRUE	Joint Workgroup recomm	February 2	16	Complete		TRUE	Deleted from CPT		
22521	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	Deleted fr	Site of Ser	September 2007							FALSE			TRUE	Joint Workgroup recomm	February 2	16	Complete		TRUE	Deleted from CPT		
22522	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	Deleted fr	Codes Rep	April 2014							FALSE			FALSE		February 2	16	Complete		TRUE	Deleted from CPT		
22523	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	Deleted fr	CMS Requ	September 2011							FALSE			FALSE		February 2	16	Complete		TRUE	Deleted from CPT		
22524	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	Deleted fr	CMS Requ	September 2011							FALSE			FALSE		February 2	16	Complete		TRUE	Deleted from CPT		
22525	Percutaneous	Percutaneous Verte	April 2014	06			AANS, CNS	Deleted fr	CMS Requ	September 2011							FALSE			FALSE		February 2	16	Complete		TRUE	Deleted from CPT		
22533	Arthrodesis, la	Arthrodesis	September 201	51			AAOS, NAS	Remove fr	CMS Faste	October 2(	090	24.79	NA	18.10	5.96	908	TRUE	Oct 2009	Yes	FALSE						TRUE	Remove from Screen		
22551	Arthrodesis, ar	Arthrodesis	February 2010	05			NASS, AAN	24.50	Codes Rep	February 2	090	25	NA	17.59	7.64	40145	FALSE			FALSE		October 2(	21			TRUE	Decrease		
22552	Arthrodesis, ar	Arthrodesis	February 2010	05			NASS, AAN	6.50	Codes Rep	February 2	ZZZ	6.5	NA	3.20	1.94	35696	FALSE			FALSE		October 2(	21			TRUE	Maintain		
22554	Arthrodesis, ar	Arthrodesis	February 2010	5			NASS, AAN	17.69	Codes Rep	February 2	090	17.69	NA	14.17	5.27	4675	FALSE			TRUE	Referred to the CPT Edito	October 2(	21	Complete		TRUE	Maintain		
22558	Arthrodesis, ar	Vertebral Corpecton	January 2017	30	October 2(	RAW	AANS/CNS	Review ac	High Volur	April 2013	090	23.53	NA	15.54	6.05	20376	FALSE			TRUE	In January 2015 the Joint	Septembe	20	yes		FALSE			
22585	Arthrodesis, ar	Arthrodesis	February 2010	05			NASS, AAN	Remove fr	Codes Rep	February 2	ZZZ	5.52	NA	2.57	1.50	17132	FALSE			FALSE		October 2(	21			TRUE	Maintain		
22612	Arthrodesis, pc	Lumbar Arthrodesis	October 2015	21			AANS/CNS	Review uti	Codes Rep	February 2	090	23.53	NA	16.98	6.31	44894	FALSE			TRUE	The Workgroup accepts t	October 2(	16	Complete		TRUE	Maintain		
22614	Arthrodesis, pc	Lumbar Arthrodesis	February 2011	04			AANS/CNS	6.43	Codes Rep	February 2	ZZZ	6.43	NA	3.19	1.88	144296	FALSE			FALSE						TRUE	Decrease		
22630	Arthrodesis, pc	Lumbar Arthrodesis	February 2011	04			AANS/CNS	22.09	Codes Rep	February 2	090	22.09	NA	17.38	7.12	5654	FALSE			TRUE	The Workgroup accepts t	October 2(	16	Complete		TRUE	Maintain		
22632	Arthrodesis, pc	Lumbar Arthrodesis	February 2011	04			AANS/CNS	5.22	Codes Rep	February 2	ZZZ	5.22	NA	2.56	1.63	1875	FALSE			FALSE						TRUE	Decrease		
22633	Arthrodesis, cc	Lumbar Arthrodesis	February 2011	04			AANS/CNS	27.75	Codes Rep	February 2	090	27.75	NA	18.89	7.96	38096	FALSE			TRUE		October 2(	16	Complete		TRUE	Decrease		
22634	Arthrodesis, cc	Lumbar Arthrodesis	February 2011	04			AANS/CNS	8.16	Codes Rep	February 2	ZZZ	8.16	NA	4.04	2.37	14338	FALSE			TRUE		October 2(	16	Complete		TRUE	Decrease		
22843	Posterior segn	Spine Fixation Devic	February 2009	38			AAOS, NAS	Remove fr	CMS Faste	October 2(	ZZZ	13.44	NA	6.67	3.87	8692	FALSE			FALSE						TRUE	Remove from Screen		
22849	Reinsertion of	RAW	September 201	21			AAOS, NAS	Maintain	CMS Faste	October 2(	090	19.17	NA	14.05	5.38	4231	FALSE			TRUE	The Workgroup recomme	June 2010	10	Complete Ir		TRUE	Maintain		
22851	Application of	Biomechancial Devic	January 2016	06		RUC	AANS/CNS	Deleted fr	CMS Faste	October 2008							FALSE			TRUE	While preparing to survey	October 2(	14	Code Delete		TRUE	Deleted from CPT		
22859	Insertion of int	Biomechancial Devic	January 2016	06			AAOS, AA	6.00	CMS High	October 2(	ZZZ	5.5	NA	2.72	1.59	1934	FALSE			FALSE						TRUE	Decrease		
22867	Insertion of int	Insertion of Interlar	January 2021	26			AAOS, AA	15.00	CMS High	October 2(	090	13.5	NA	11.54	4.02	2131	FALSE			FALSE						TRUE	Increase		
22868	Insertion of int	Biomechancial Devic	January 2016	06			AAOS, AA	5.50	CMS High	October 2(	ZZZ	4	NA	1.96	1.25	532	FALSE			FALSE						TRUE	Decrease		
22900	Excision, tumo	Subfascial Excision o	February 2009	5			ACS, AAOS	8.21	Site of Ser	Septembe	090	8.32	NA	6.48	1.89	628	FALSE			TRUE	CPT developed new codir	June 2008	06	New code s		TRUE	Increase		

23076	Excision, tumo	Subfascial Excision o	February 2009	5		ACS, AAOS	7.28	Site of Ser	Septembe	090	7.41	NA	7.02	1.57	677	FALSE			TRUE	CPT developed new codir	June 2008	06	New code s	TRUE	Decrease
23120	Claviculectom	Claviculectomy	April 2008	30		AAOS	7.23	Site of Ser	Septembe	090	7.39	NA	8.52	1.46	6767	FALSE			FALSE					TRUE	Maintain
23130	Acromioplasty	Removal of Bone	September 200	16		AAOS	Reduce 99	Site of Ser	Septembe	090	7.77	NA	8.95	1.55	1826	FALSE			FALSE					TRUE	PE Only
23350	Injection proce	Injection for Shoulde	September 201	13		ACR, AAOS	1.00	Harvard V	April 2011	000	1	3.80	0.37	0.09	35070	FALSE			FALSE					TRUE	Maintain
23405	Tenotomy, shc	Tenotomy	September 200	16		AAOS	Reduce 99	Site of Ser	Septembe	090	8.54	NA	8.24	1.53	2277	FALSE			FALSE					TRUE	PE Only
23410	Repair of rupt	Rotator Cuff	February 2008	12		AAOS	11.23	Site of Ser	Septembe	090	11.39	NA	10.61	2.22	3333	FALSE			FALSE					TRUE	Decrease
23412	Repair of rupt	Rotator Cuff	September 201	21		AAOS	Maintain v	Site of Ser	Septembe	090	11.93	NA	10.91	2.32	12002	FALSE			FALSE					TRUE	Decrease
23415	Coracoacromi	Shoulder Ligament F	October 2010	62		AAOS	9.23	Site of Ser	Septembe	090	9.23	NA	9.58	1.82	408	FALSE			FALSE					TRUE	Decrease
23420	Reconstructior	Rotator Cuff	February 2008	12		AAOS	13.35	Site of Ser	Septembe	090	13.54	NA	12.52	2.68	2359	FALSE			FALSE					TRUE	Decrease
23430	Tenodesis of lc	Tenodesis	October 2009	12		AAOS	10.17	CMS Faste	Septembe	090	10.17	NA	9.89	1.93	19997	FALSE			FALSE					TRUE	Maintain
23440	Resection or tr	Tendon Transfer	September 200	16		AAOS	Reduce 99	Site of Ser	Septembe	090	10.64	NA	9.61	2.10	1487	FALSE			FALSE					TRUE	PE Only
23472	Arthroplasty, g	Arthroplasty	October 2015	21		AAOS	Remove fr	CMS Faste	October 2	090	22.13	NA	16.29	4.25	67382	FALSE			FALSE					TRUE	Remove from Screen
23540	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	2.36	4.19	4.11	0.46	339	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
23600	Closed treatm	Treatment of Humer	September 201	14		AAOS	3.00	Harvard V	April 2011	090	3	6.32	5.76	0.59	32747	FALSE			FALSE					TRUE	Decrease
23625	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	4.1	6.43	5.50	0.79	173	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
23650	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	3.53	5.37	4.47	0.70	14692	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
23655	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	4.76	NA	6.41	0.93	2327	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
23665	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	4.66	7.24	6.24	0.92	556	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
24505	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	5.39	8.49	6.96	1.07	890	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
24600	Treatment of c	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	4.37	5.82	4.78	0.86	1283	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
24605	Treatment of c	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	5.64	NA	7.43	1.10	382	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
25116	Radical excisio	Forearm Excision	October 2010	63		ASSH, AAC	7.56	Site of Ser	Septembe	090	7.56	NA	8.89	1.37	1034	FALSE			FALSE					TRUE	Maintain
25210	Carpectomy; 1	Carpectomy	September 200	16		AAOS	Reduce 99	Site of Ser	Septembe	090	6.12	NA	7.35	1.10	3150	FALSE			FALSE					TRUE	PE Only
25260	Repair, tendor	Tendon Repair	September 200	16		AAOS	Reduce 99	Site of Ser	Septembe	090	8.04	NA	9.21	1.46	919	FALSE			FALSE					TRUE	PE Only
25280	Lengthening o	Tendon Repair	September 200	16		AAOS	Reduce 99	Site of Ser	Septembe	090	7.39	NA	8.02	1.35	1402	FALSE			FALSE					TRUE	PE Only
25310	Tendon transp	Forearm Repair	February 2008	15		ASSH, AAC	7.94	Site of Ser	Septembe	090	8.08	NA	8.81	1.46	7690	FALSE			FALSE					TRUE	Decrease
25565	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	5.85	8.38	6.78	1.15	667	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
25605	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	6.25	8.59	7.68	1.24	20527	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
25606	Percutaneous	RAW	September 201	21		AAOS, ASS	Maintain v	Pre-Time A	Septembe	090	8.31	NA	9.77	1.62	2015	FALSE			FALSE					TRUE	Maintain
25607	Open treatmer	RAW	September 201	21		AAOS, ASS	Maintain v	Pre-Time A	Septembe	090	9.56	NA	10.43	1.82	9419	FALSE			FALSE					TRUE	Maintain
25608	Open treatmer	RAW	September 201	21		AAOS, ASS	Maintain v	Pre-Time A	Septembe	090	11.07	NA	11.23	2.10	7290	FALSE			FALSE					TRUE	Maintain
25609	Open treatmer	RAW	September 201	21		AAOS, ASS	Maintain v	Pre-Time A	January 2(	090	14.38	NA	13.92	2.68	18114	FALSE			FALSE					TRUE	Maintain
25675	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	4.89	7.39	6.10	0.96	445	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
26020	Drainage of te	Tendon Sheath Proc	April 2018	07		AAOS, ASP	7.79	Negative I'	April 2017	090	6.84	NA	8.34	1.25	2453	FALSE			FALSE					TRUE	Increase
26055	Tendon sheath	Tendon Sheath Proc	April 2018	07		AAOS, ASP	3.75	Negative I'	April 2017	090	3.11	13.80	4.93	0.58	105433	FALSE			FALSE					TRUE	Increase
26080	Arthrotomy, w	RAW	October 2015	21	RAW	ASSH, AAC	Action pla	Site of Ser	Septembe	090	4.47	NA	6.50	0.79	1997	TRUE	Sep 2012	Yes	FALSE					TRUE	Maintain
26160	Excision of lesi	Tendon Sheath Proc	April 2018	07		AAOS, ASP	3.57	Negative I'	April 2017	090	3.57	13.97	5.13	0.64	18598	FALSE			FALSE					TRUE	Maintain
26356	Repair or adva	Repair Flexor Tendo	April 2015	25	RUC	AAOS, ASP	10.03	Site of Ser	Septembe	090	9.56	NA	12.28	1.73	1150	FALSE			FALSE					TRUE	Decrease
26357	Repair or adva	Repair Flexor Tendo	April 2015	25	RUC	AAOS, ASP	11.50	090-Day G	April 2014	090	11	NA	13.25	2.21	66	FALSE			FALSE					TRUE	Increase
26358	Repair or adva	Repair Flexor Tendo	April 2015	25	RUC	AAOS, ASP	13.10	090-Day G	April 2014	090	12.6	NA	14.08	2.53	42	FALSE			FALSE					TRUE	Increase
26480	Transfer or tra	Tendon Transfer	April 2009	26		AAOS, ASS	6.76	CMS Faste	October 2	090	6.9	NA	15.38	1.24	10824	FALSE			FALSE					TRUE	Maintain
26700	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	3.83	5.38	4.61	0.74	471	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
26750	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	1.8	3.40	3.43	0.34	6976	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
26755	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	3.23	5.67	4.32	0.63	522	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
26770	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	3.15	4.68	3.93	0.61	5900	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27048	Excision, tumo	Excision of Subfascia	February 2009	05		ACS, AAOS	8.74	Site of Ser	Septembe	090	8.85	NA	7.31	1.91	339	FALSE			TRUE	CPT developed new codir	June 2008	06	New code s	TRUE	Increase
27062	Excision; troch	Trochanteric Bursa E	April 2008	32		AAOS	5.66	Site of Ser	Septembe	090	5.75	NA	6.60	1.13	1884	FALSE			FALSE					TRUE	Maintain
27096	Injection proce	Injection for Sacroilia	April 2011	06		AAPM, AA	1.48	Different F	October 2	000	1.48	3.26	0.81	0.14	489612	FALSE			TRUE	Refer to CPT Editorial Pan	February 2	76	Code Revise	TRUE	Decrease
27130	Arthroplasty, a	Hip/Knee Arthroplas	October 2019	11		AAOS, AAH	19.60	CMS High	Septembe	090	19.6	NA	14.40	3.90	169584	FALSE			FALSE					TRUE	Decrease
27134	Revision of tot	RAW	September 201	21		AAOS, AAH	Maintain v	Pre-Time A	January 2(	090	30.28	NA	19.86	6.01	10863	FALSE			FALSE					TRUE	Maintain
27193	Closed treatm	Closed Treatment of	January 2016	07		AAOS	Deleted fr	CMS Requ	July 2013							FALSE			TRUE	Refer to CPT for deletion.	October 2015		Code Delete	TRUE	Deleted from CPT
27194	Closed treatm	Closed Treatment of	January 2016	07		AAOS	Deleted fr	CMS Requ	October 2015							FALSE			FALSE				Code Delete	TRUE	Deleted from CPT
27197	Closed treatm	Closed Treatment of	January 2016	07		AAOS	5.50	CMS Requ	October 2	000	1.53	NA	2.07	0.30	11080	FALSE			FALSE					TRUE	Decrease
27198	Closed treatm	Closed Treatment of	January 2016	07		AAOS	9.00	CMS Requ	October 2	000	4.75	NA	3.74	0.86	206	FALSE			FALSE					TRUE	Decrease
27220	Closed treatm	Closed Treatment Fr	April 2018	08		AAOS	6.00	Negative I'	April 2017	090	5.5	5.78	5.61	1.10	3070	FALSE			FALSE					TRUE	Decrease
27230	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	5.81	7.43	7.17	1.15	1509	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27232	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	11.72	NA	7.83	2.32	194	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27236	Open treatmer	Open Treatment of I	October 2012	16		AAOS	17.61	CMS High	Septembe	090	17.61	NA	14.10	3.47	57280	FALSE			FALSE					TRUE	Maintain
27240	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	13.81	NA	11.78	2.74	260	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27244	Treatment of i	Treat Thigh Fracture	October 2008	12		AAOS	18.00	High IWPL	April 2008	090	18.18	NA	14.43	3.60	5947	FALSE			FALSE					TRUE	Increase
27245	Treatment of i	Treat Thigh Fracture	October 2008	12		AAOS	18.00	High IWPL	February 2	090	18.18	NA	14.41	3.58	83430	FALSE			FALSE					TRUE	Decrease
27250	Closed treatm	Closed Treatment of	February 2008	18		ACEP	3.82	Site of Ser	Septembe	000	3.82	NA	0.73	0.75	3180	FALSE			FALSE					TRUE	Decrease
27252	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	11.03	NA	9.11	2.21	762	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27265	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	5.24	NA	5.75	1.03	8333	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27266	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	7.78	NA	7.98	1.53	5456	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27279	Arthrodesis, sa	Arthodesis - Sacroilia	April 2018	09		AANS, AAC	9.03	CMS Requ	July 2017	090	12.13	NA	10.28	3.04	3753	FALSE			FALSE					TRUE	Maintain
27324	Biopsy, soft tis	Soft Tissue Biopsy	September 200	16		ACS, AAOS	Reduce 99	Site of Ser	Septembe	090	5.04	NA	5.87	1.14	814	FALSE			FALSE					TRUE	PE Only
27369	Injection proce	Knee Arthrography I	October 2017	05		ACR	0.96	Harvard V	June 2017	000	0.77	4.22	0.30	0.10	60267	FALSE			TRUE	In June 2017, the CPT Edi	February 2	EC-O	complete	TRUE	Maintain
27370	Injection of co	Knee Arthrography I	October 2017	05		ACR	Deleted fr	High Volur	February 2008							TRUE	Clinical Exa	Yes	TRUE	In October 2016, the RUC	June 2017	09	yes	TRUE	Deleted from CPT
27446	Arthroplasty, k	Knee Arthroplasty	April 2021	18		AAOS, AAH	17.13	CMS High	Septembe	090	17.48	NA	13.11	3.44	15803	FALSE			FALSE					TRUE	Decrease
27447	Arthroplasty, k	Hip/Knee Arthroplas	April 2021	18		AAOS, AAH	19.60	CMS High	Septembe	090	19.6	NA	14.37	3.88	312130	FALSE			FALSE					TRUE	Decrease
27502	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	11.36	NA	8.76	2.22	385	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27510	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	9.8	NA	8.41	1.92	386	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27550	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	5.98	8.46	7.25	1.19	531	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27552	Closed treatm	PE Subcommittee	April 2016	46		AAOS, ACE	PE Clinical	Emergent	October 2	090	8.18	NA	8.95	1.62	269	TRUE	Jan 2018	yes	FALSE					TRUE	PE Only
27615	Radical resecti	Radical Resecion of :	February 2009	6		ACS, AAOS	15.54	Site of Ser	Septembe	090	15.72	NA	11.22	3.20	211	FALSE			TRUE	CPT developed new codir	June 2008	06	New code s	TRUE	Increase
27619	Excision, tumo	Excision of Subfascia	February 2009	5		ACS, AAOS	6.80	Site of Ser	Septembe	090	6.91	NA	5.54	1.10	552	FALSE			TRUE	CPT developed new codir	June 2008	06	New code s	TRUE	Decrease
27640	Partial excisior	Leg Bone Resection	February 2008	19		AOFAS, AA	12.10	Site of Ser	Septembe	090	12.24	NA	10.13	2.15	1673	FALSE			TRUE	CPT Editorial Panel addre	June 2008	07	Complete	TRUE	Maintain
27641	Partial excisior	Leg Bone Resection	February 2008	19		AOFAS, AA	9.72	Site of Ser	February 2	090	9.84	NA	7.91	1.59	905	FALSE			TRUE	CPT Editorial Panel addre	June 2008	07	Complete	TRUE	Decrease
27650	Repair, primar	Achilles Tendon Rep	February 2008	20		AAOS, AOF	9.00	Site of Ser	Septembe	090	9.21	NA	8.78	1.44	2516	FALSE			FALSE					TRUE	Decrease

27654	Repair, second	Achilles Tendon Rep	April 2008	33			AOFAS, AP	10.32	Site of Ser	Septembe	090	10.53	NA	8.89	1.51	3117	FALSE			FALSE							TRUE	Maintain		
27685	Lengthening o	Tendon Repair	September 200	16			AAOS	Reduce 99	Site of Ser	Septembe	090	6.69	12.08	6.05	0.90	4084	FALSE			FALSE							TRUE	PE Only		
27687	Gastrocnemiu	Tendon Repair	September 200	16			AAOS	Reduce 99	Site of Ser	Septembe	090	6.41	NA	6.02	0.93	7093	FALSE			FALSE							TRUE	PE Only		
27690	Transfer or tra	Tendon Transfer	April 2008	34			AOFAS, AP	8.96	Site of Ser	Septembe	090	9.17	NA	8.39	1.35	1376	FALSE			FALSE							TRUE	Maintain		
27691	Transfer or tra	Tendon Transfer	April 2008	34			AOFAS, AP	10.28	Site of Ser	Septembe	090	10.49	NA	9.72	1.73	4579	FALSE			FALSE							TRUE	Maintain		
27752	Closed treatm	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical	Emergent	October 2(	090	6.27	8.42	7.06	1.25	1229	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only		
27762	Closed treatm	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical	Emergent	October 2(	090	5.47	7.69	6.33	1.03	369	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only		
27792	Open treatme	Treatment of Ankle	February 2011	18			AAOS, AOF	9.71	Site of Ser	June 2010	090	8.75	NA	8.74	1.59	7279	FALSE			FALSE							TRUE	Maintain		
27810	Closed treatm	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical	Emergent	October 2(	090	5.32	7.64	6.25	1.03	2962	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only		
27814	Open treatme	RAW	September 201	21			AAOS	Maintain v	Pre-Time A	January 2(	090	10.62	NA	10.01	1.98	10858	FALSE			FALSE							TRUE	Maintain		
27818	Closed treatm	Treatment of Fractu	April 2016	46			AAOS, ACE	PE Clinical	Site of Ser	Septembe	090	5.69	7.71	6.15	1.10	3490	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only		
27825	Closed treatm	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical	Emergent	October 2(	090	6.69	8.17	6.59	1.28	659	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only		
27840	Closed treatm	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical	Emergent	October 2(	090	4.77	NA	5.53	0.93	2234	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only		
28001	Incision and dr	Treatment of Foot Ir	October 2020	14			AAOS, AOF	2.00	010-Day G	April 2020	010	2.78	5.09	1.87	0.25	3770	FALSE			FALSE							TRUE	Decrease		
28002	Incision and dr	Treatment of Foot Ir	October 2020	14			AAOS, AOF	3.50	010-Day G	January 2(	010	5.34	7.01	3.34	0.54	6661	FALSE			FALSE							TRUE	Decrease		
28003	Incision and dr	Treatment of Foot Ir	October 2020	14			AAOS, AOF	5.28	010-Day G	April 2020	090	9.06	10.59	6.33	1.02	5470	FALSE			FALSE							TRUE	Decrease		
28111	Ostectomy, co	Ostectomy	September 200	16			APMA, AA	Reduce 99	Site of Ser	Septembe	090	5.15	8.71	3.71	0.56	1069	FALSE			FALSE							TRUE	PE Only		
28120	Partial excisior	Removal of Foot Bor	February 2011	19			AOFAS, AP	8.27	Site of Ser	Septembe	090	7.31	11.80	6.30	0.96	5154	FALSE			FALSE							TRUE	Increase		
28122	Partial excisior	Removal of Foot Bor	February 2011	19			AOFAS, AP	7.72	Site of Ser	Septembe	090	6.76	10.10	5.30	0.71	14469	FALSE			FALSE							TRUE	Maintain		
28124	Partial excisior	Toe Removal	September 200	16			APMA, AA	Remove 9!	Site of Ser	Septembe	090	5	8.71	4.25	0.45	11425	FALSE			FALSE							TRUE	PE Only		
28285	Correction, ha	Orthopaedic Surger	October 2010	31			AAOS, AOF	5.62	Harvard Vi	February 2	090	5.62	9.73	4.95	0.56	71537	FALSE			FALSE							TRUE	Increase		
28289	Hallux rigidus	Bunionectomy	January 2016	08			AAOS, AOF	6.90	090-Day G	October 2(	090	6.9	13.18	5.72	0.75	4662	FALSE			FALSE				October 2(	19	Complete	TRUE	Decrease		
28290	Correction, hal	Bunionectomy	January 2016	08			AAOS, AOF	Deleted fr	090-Day G	October 2015							FALSE			FALSE				October 2(	19	Complete	TRUE	Deleted from CPT		
28291	Hallux rigidus	Bunionectomy	January 2016	08			AAOS, AOF	8.01	090-Day G	October 2(	090	8.01	12.74	5.60	0.78	4067	FALSE			FALSE				October 2(	19	Complete	TRUE	Decrease		
28292	Correction, hal	Bunionectomy	January 2016	08			AAOS, AOF	7.44	090-Day G	October 2(	090	7.44	12.86	5.88	0.71	6950	FALSE			FALSE				October 2(	19	Complete	TRUE	Decrease		
28293	Correction, hal	Bunionectomy	January 2016	08			AAOS, AOF	Deleted fr	090-Day G	January 2014							FALSE			TRUE	In January 2014, the RUC			October 2(	19	Complete	TRUE	Deleted from CPT		
28294	Correction, hal	Bunionectomy	January 2016	08			AAOS, AOF	Deleted fr	090-Day G	October 2015							FALSE			FALSE				October 2(	19	Complete	TRUE	Deleted from CPT		
28295	Correction, hal	Bunionectomy	January 2016	08			AAOS, AOF	8.57	090-Day G	October 2(	090	8.57	23.38	8.29	1.30	586	FALSE			FALSE				October 2(	19	Complete	TRUE	Decrease		
28296	Correction, hal	Bunionectomy	January 2016	08			AAOS, AOF	8.25	Site of Ser	Septembe	090	8.25	17.86	5.94	0.74	9559	FALSE			FALSE				October 2(	19	Complete	TRUE	Decrease		
28297	Correction, hal	Bunionectomy	January 2016	08			AAOS, AOF	9.29	090-Day G	October 2(	090	9.29	20.85	7.24	1.10	2793	FALSE			FALSE				October 2(	19	Complete	TRUE	Decrease		
28298	Correction, hal	Bunionectomy	January 2016	08			AAOS, AOF	7.75	Site of Ser	Septembe	090	7.75	16.46	6.00	0.86	2903	FALSE			FALSE				October 2(	19	Complete	TRUE	Decrease		
28299	Correction, hal	Bunionectomy	January 2016	08			AAOS, AOF	9.29	090-Day G	October 2(	090	9.29	19.90	6.82	0.99	4743	FALSE			FALSE				October 2(	19	Complete	TRUE	Decrease		
28300	Osteotomy; ca	Osteotomy	September 200	16			AAOS	Reduce 99	Site of Ser	Septembe	090	9.73	NA	7.88	1.51	2519	FALSE			FALSE							TRUE	PE Only		
28310	Osteotomy, sh	Osteotomy	September 200	16			APMA, AA	Reduce 99	Site of Ser	Septembe	090	5.57	10.09	4.37	0.62	1640	FALSE			FALSE							TRUE	PE Only		
28470	Closed treatm	Treatment of Metat	September 201	15			AAOS, APN	2.03	Harvard Vi	April 2011	090	2.03	4.14	3.72	0.28	29629	FALSE			FALSE							TRUE	Maintain		
28660	Closed treatm	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical	Emergent	October 2(	010	1.28	2.07	1.21	0.22	689	TRUE	Jan 2018	yes	FALSE							TRUE	PE Only		
28725	Arthrodesis; s	Foot Arthrodesis	February 2011	20			AOFAS, AP	12.18	Site of Ser	Septembe	090	11.22	NA	9.84	1.81	4389	FALSE			FALSE							TRUE	Maintain		
28730	Arthrodesis, m	Foot Arthrodesis	February 2011	20			AOFAS, AP	12.42	Site of Ser	Septembe	090	10.7	NA	9.25	1.63	3581	FALSE			FALSE							TRUE	Maintain		
28740	Arthrodesis, m	Arthrodesis	September 200	16			AAOS	Reduce 99	Site of Ser	Septembe	090	9.29	14.18	7.58	1.25	3996	FALSE			FALSE							TRUE	PE Only		
28820	Amputation, to	Toe Amputation	April 2019	11			AAOS, ACS	4.10	Site of Ser	October 2(	000	3.51	5.16	1.34	0.44	30702	FALSE			FALSE							TRUE	Decrease		
28825	Amputation, to	Toe Amputation	April 2019	11			AAOS, ACS	4.00	Site of Ser	Septembe	000	3.41	5.09	1.30	0.42	15013	FALSE			FALSE							TRUE	Decrease		
29075	Application, ca	Application of Forea	September 201	16			AAOS, ASS	0.77	Harvard Vi	April 2011	000	0.77	1.62	0.90	0.15	68396	FALSE			FALSE							TRUE	Maintain		
29105	Application of	Application of Long /	April 2017	11			AAOS, ACE	0.80	CMS 000-D	July 2016	000	0.8	1.45	0.29	0.15	25626	FALSE			FALSE							TRUE	Decrease		
29200	Strapping; tho	Strapping Procedure	January 2014	35			APTA	0.39	High Volur	April 2013	000	0.39	0.56	0.13	0.02	13693	FALSE			FALSE							TRUE	Decrease		
29220	Deleted from (	Strapping; low back	April 2008	57			AAFP	Deleted fr	High Volur	February 2008							TRUE	Deleted fr	Yes	TRUE	The specialty society was	October 2(	10	Code Delete			TRUE	Deleted from CPT		
29240	Strapping; sho	Strapping Procedure	January 2014	35			APTA	0.39	High Volur	April 2013	000	0.39	0.49	0.13	0.02	16307	FALSE			FALSE							TRUE	Decrease		
29260	Strapping; elbo	Strapping Procedure	January 2014	35			APTA	0.39	High Volur	October 2(	000	0.39	0.45	0.14	0.04	5004	FALSE			FALSE							TRUE	Decrease		
29280	Strapping; han	Strapping Procedure	January 2014	35			APTA	0.39	High Volur	October 2(	000	0.39	0.43	0.14	0.04	3404	FALSE			FALSE							TRUE	Decrease		
29445	Application of	Application of Rigid	April 2016	17			AAOS, AHI	1.78	High Volur	October 2(	000	1.78	1.78	0.94	0.21	36431	FALSE			FALSE							TRUE	Maintain		
29520	Strapping; hip	Strapping Procedure	January 2014	35			APTA	0.39	High Volur	April 2013	000	0.39	0.64	0.13	0.02	13018	FALSE			FALSE							TRUE	Decrease		
29530	Strapping; kne	Strapping Procedure	January 2014	35			APTA	0.39	High Volur	April 2013	000	0.39	0.48	0.12	0.02	27045	FALSE			FALSE							TRUE	Decrease		
29540	Strapping; ank	Strapping Lower Ext	April 2017	41ii			APMA	0.39	Harvard Vi	October 2(	000	0.39	0.39	0.09	0.04	213060	FALSE			FALSE							TRUE	Decrease		
29550	Strapping; toe	Strapping Lower Ext	April 2017	41ii			APMA	0.25	Harvard Vi	February 2	000	0.25	0.28	0.06	0.02	56200	FALSE			FALSE							TRUE	Decrease		
29580	Strapping; unn	Strapping Multi Laye	October 2016	13		RUC	ACS, APM/	0.55	CMS High	July 2015	000	0.55	1.26	0.16	0.06	265752	FALSE			FALSE							TRUE	Maintain		
29581	Application of	Strapping Multi Laye	October 2016	13			ACS, APM/	0.60	CMS High	July 2015	000	0.6	2.03	0.18	0.02	194064	FALSE			FALSE							TRUE	Maintain		
29582	Application of	New Technology Re	October 2015	21			APTA	Deleted fr	New Techi	October 2015							TRUE	Aug 2016	Yes	FALSE		Septembe	22	yes			TRUE	Deleted from CPT		
29583	Application of	New Technology Re	October 2015	21			APTA	Deleted fr	New Techi	October 2015							TRUE	Aug 2016	Yes	FALSE		Septembe	22	yes			TRUE	Deleted from CPT		
29584	Application of	New Technology Re	October 2018	27	January 2(	RAW	APTA	Develop C	New Techi	October 2(	000	0.35	2.12	0.10	0.01	2715	TRUE	Aug 2016	Yes	FALSE							FALSE			
29590	Denis-Browne	Dennis-Browne splir	April 2012	07			APMA	Deleted fr	Harvard Vi	February 2010							FALSE			TRUE	This service was identifie	February 2	08	Code Delete			TRUE	Deleted from CPT		
29805	Arthroscopy, s	Arthroscopy	April 2008	51			AAOS	No NF PE i	CMS Requ	NA	090	6.03	NA	6.74	1.16	698	FALSE			FALSE							TRUE	PE Only		
29822	Arthroscopy, s	Shoulder Debrideme	January 2020	11				7.03	CMS Faste	October 2(	090	7.03	NA	7.61	1.39	9153	FALSE			TRUE	In October 2018, AMA sta	Septembe	14	yes			TRUE	Decrease		
29823	Arthroscopy, s	Shoulder Debrideme	January 2020	11				7.98	Harvard-V	October 2(	090	7.98	NA	8.03	1.52	45349	FALSE			TRUE	In October 2018, AMA sta	Septembe	14	yes			TRUE	Decrease		
29824	Arthroscopy, s	RAW	October 2015	21			AAOS	8.82	Codes Rep	February 2	090	8.98	NA	9.29	1.73	39895	FALSE			FALSE							TRUE	Maintain		
29826	Arthroscopy, s	RAW	October 2015	21			AAOS	3.00	Codes Rep	February 2	ZZZ	3	NA	1.52	0.59	78655	FALSE			FALSE							TRUE	Decrease		
29827	Arthroscopy, s	RAW	October 2015	21			AAOS	15.59. Mai	CMS Faste	October 2(	090	15.59	NA	12.97	2.98	69465	FALSE			FALSE							TRUE	Maintain		
29828	Arthroscopy, s	RAW	October 2015	21			AAOS	13.16	Codes Rep	February 2	090	13.16	NA	11.38	2.53	18992	FALSE			FALSE							TRUE	Maintain		
29830	Arthroscopy, e	Arthroscopy	April 2008	51			AAOS	No NF PE i	CMS Requ	NA	090	5.88	NA	6.50	1.00	136	FALSE			FALSE							TRUE	PE Only		
29840	Arthroscopy, v	Arthroscopy	April 2008	51			AAOS	No NF PE i	CMS Requ	NA	090	5.68	NA	6.66	1.02	125	FALSE			FALSE							TRUE	PE Only		
29870	Arthroscopy, k	Arthroscopy	October 2009	13			AAOS	New PE nc	CMS Requ	NA	090	5.19	10.58	5.85	0.97	1031	FALSE			FALSE							TRUE	PE Only		
29888	Arthroscopical	ACL Repair	April 2008	38			AAOS	14.14	Site of Ser	Septembe	090	14.3	NA	11.84	2.70	1173	FALSE			FALSE							TRUE	Maintain		
29900	Arthroscopy, n	Arthroscopy	April 2008	51			AAOS	No NF PE i	CMS Requ	NA	090	5.88	NA	7.79	1.17	4	FALSE			FALSE							TRUE	PE Only		
30140	Submucous re	Resection of Inferior	October 2016	14		RUC	AAOHNS	3.00	Harvard Vi	October 2(	000	3	5.28	1.75	0.43	49954	FALSE			FALSE							TRUE	Decrease		
30465	Repair of nasa	Repair Nasal Stenosi	September 200	16			AAO-HNS	Reduce 99	Site of Ser	Septembe	090	12.36	NA	16.15	1.73	4626	FALSE			FALSE							TRUE	PE Only		
30901	Control nasal h	Control Nasal Hemo	April 2016	20			AAOHNS	1.10	Harvard Vi	October 2(	000	1.1	3.36	0.37	0.17	88372	FALSE			FALSE							TRUE	Maintain		
30903	Control nasal h	Control Nasal Hemo	April 2016	20			AAOHNS	1.54	CMS Requ	July 2015	000	1.54	5.49	0.47	0.26	48496	FALSE			FALSE							TRUE	Maintain		
30905	Control nasal h	Control Nasal Hemo	April 2016	20			AAOHNS	1.97	CMS Requ	July 2015	000	1.97	8.29	0.78	0.34	5245	FALSE			FALSE							TRUE	Maintain		
30906	Control nasal h	Control Nasal Hemo	April 2016	20			AAOHNS	2.45	CMS Requ	July 2015	000	2.45	8.13	1.14	0.36	800	FALSE			FALSE							TRUE	Maintain		
31231	Nasal endosco	Nasal/Sinus Endoscc	January 2012	19			AAO-HNS	1.10	MPC List	October 2(	000	1.1	4.54	0.61	0.15	660545	FALSE			FALSE							TRUE	Maintain		
31237	Nasal/sinus en	Nasal/Sinus Endoscc	April 2013	19			AAO-HNS	2.60	CMS High	Septembe	000	2.6	4.56	1.65	0.36	137754	FALSE			FALSE							TRUE	Decrease		
31238	Nasal/sinus en	Nasal/Sinus Endoscc	April 2013	19			AAO-HNS	2.74	CMS High	January 2(	000	2.74	4.25	1.71	0.38	29505	FALSE			FALSE							TRUE	Decrease		

31239	Nasal/sinus en	Nasal/Sinus Endoscc	April 2013	19		AAO-HNS	9.04	CMS High	January 2C	010	9.04	NA	7.80	0.93	1366	FALSE			FALSE						TRUE	Decrease
31240	Nasal/sinus en	Nasal/Sinus Endoscc	April 2013	19		AAO-HNS	2.61	CMS High	January 2C	000	2.61	NA	1.62	0.36	6458	FALSE			FALSE						TRUE	Maintain
31241	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	8.51	Codes Rep	April 2015	000	8	NA	3.78	1.10	470	FALSE			FALSE		Septembe 24		yes		TRUE	Decrease
31253	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	9.00	Codes Rep	April 2015	000	9	NA	4.26	1.25	8502	FALSE			FALSE		Septembe 24		yes		TRUE	Decrease
31254	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	4.27	CMS Requ	July 2015	000	4.27	8.03	2.19	0.59	13255	FALSE			FALSE		Septembe 24		yes		TRUE	Decrease
31255	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	5.75	Codes Rep	April 2015	000	5.75	NA	2.84	0.78	11287	FALSE			TRUE	In April 2015, the Joint CP	Septembe 24		yes		TRUE	Decrease
31256	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	3.11	CMS Requ	July 2015	000	3.11	NA	1.68	0.43	15592	FALSE			FALSE		Septembe 24		yes		TRUE	Decrease
31257	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	8.00	Codes Rep	April 2015	000	8	NA	3.83	1.10	5920	FALSE			FALSE		Septembe 24		yes		TRUE	Decrease
31259	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	8.48	Codes Rep	April 2015	000	8.48	NA	4.04	1.17	7903	FALSE			FALSE		Septembe 24		yes		TRUE	Decrease
31267	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	4.68	CMS Requ	July 2015	000	4.68	NA	2.36	0.64	28703	FALSE			FALSE		Septembe 24		yes		TRUE	Decrease
31276	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	6.75	Codes Rep	April 2015	000	6.75	NA	3.27	0.93	15859	FALSE			TRUE	In April 2015, the Joint CP	Septembe 24		yes		TRUE	Decrease
31287	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	3.50	Codes Rep	April 2015	000	3.5	NA	1.84	0.48	3280	FALSE			TRUE	In April 2015, the Joint CP	Septembe 24		yes		TRUE	Decrease
31288	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	4.10	Codes Rep	April 2015	000	4.1	NA	2.11	0.58	4121	FALSE			TRUE	In April 2015, the Joint CP	Septembe 24		yes		TRUE	Decrease
31295	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	2.70	Codes Rep	April 2015	000	2.7	52.30	1.50	0.37	28533	FALSE			FALSE						TRUE	Maintain
31296	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	3.10	Codes Rep	April 2015	000	3.1	52.59	1.67	0.43	8725	FALSE			TRUE	In April 2015, the Joint CP	Septembe 24		yes		TRUE	Decrease
31297	Nasal/sinus en	Nasal/Sinus Endoscc	January 2017	07		AAOHNS	2.44	Codes Rep	April 2015	000	2.44	52.17	1.38	0.34	2120	FALSE			TRUE	In April 2015, the Joint CP	Septembe 24		yes		TRUE	Decrease
31298	Nasal/sinus en	Nasal/Sinus Endoscc	October 2020	24		AAOHNS	4.50	Codes Rep	April 2015	000	4.5	99.88	2.28	0.63	19499	FALSE			FALSE		Septembe 24		yes		TRUE	Decrease
31500	Intubation, en	Endotracheal Intuba	October 2018	27		ACEP, ASA	3.00	CMS High	July 2015	000	3	NA	0.72	0.43	263123	TRUE	Oct 2016	yes	FALSE						TRUE	Increase
31551	Laryngoplasty;	Laryngoplasty	January 2016	09		AAOHNS	21.50	090-Day G	October 2(	090	21.5	NA	20.58	2.95	2	FALSE			FALSE		October 2(	13	Complete		TRUE	Decrease
31552	Laryngoplasty;	Laryngoplasty	January 2016	09		AAOHNS	20.50	090-Day G	October 2(	090	20.5	NA	20.16	2.81	12	FALSE			FALSE		October 2(	13	Complete		TRUE	Decrease
31553	Laryngoplasty;	Laryngoplasty	January 2016	09		AAOHNS	22.00	090-Day G	October 2(	090	22	NA	24.58	3.03		FALSE			FALSE		October 2(	13	Complete		TRUE	Decrease
31554	Laryngoplasty;	Laryngoplasty	January 2016	09		AAOHNS	22.00	090-Day G	October 2(	090	22	NA	24.60	3.03	23	FALSE			FALSE		October 2(	13	Complete		TRUE	Decrease
31571	Laryngoscopy,	Laryngoscopy	September 20(	16		AAO-HNS	Reduce 99	Site of Ser	Septembe	000	4.26	NA	2.32	0.59	5271	FALSE			FALSE						TRUE	PE Only
31575	Laryngoscopy,	flexible; diagnostic	October 2015	08		AAO-HNS	1.00	MPC List /	October 2(	000	0.94	2.69	0.87	0.13	658434	FALSE			FALSE						TRUE	Decrease
31579	Laryngoscopy,	Laryngoscopy	October 2015	08		AAO-HNS	1.94	CMS Faste	October 2(	000	1.88	3.65	1.31	0.25	86928	FALSE			FALSE						TRUE	Decrease
31580	Laryngoplasty;	Laryngoplasty	January 2016	09		AAO-HNS	14.60	090-Day G	April 2014	090	14.6	NA	21.35	1.99	21	FALSE			TRUE	CPT code 31588 was iden	October 2(	13	Complete		TRUE	Decrease
31582	Laryngoplasty;	Laryngoplasty	January 2015	09		AAO-HNS	Deleted fr	090-Day G	April 2014							FALSE			TRUE	CPT code 31588 was iden	October 2(	13	Deleted fro		TRUE	Deleted from CPT
31584	Laryngoplasty;	Laryngoplasty	January 2016	09		AAO-HNS	20.00	090-Day G	April 2014	090	17.58	NA	21.83	2.42	15	FALSE			TRUE	CPT code 31588 was iden	October 2(	13	Complete		TRUE	Decrease
31587	Laryngoplasty,	Laryngoplasty	January 2016	09		AAO-HNS	15.27	090-Day G	April 2014	090	15.27	NA	17.87	2.10	15	FALSE			TRUE	CPT code 31588 was iden	October 2(	13	Complete		TRUE	Decrease
31588	Laryngoplasty,	Laryngoplasty	January 2016	09		AAO-HNS	Deleted fr	090-Day G	January 2014							FALSE			TRUE	CPT code 31588 was iden	October 2(	13	Deleted fro		TRUE	Deleted from CPT
31591	Laryngoplasty,	Laryngoplasty	January 2016	09		AAOHNS	15.60	090-Day G	October 2(	090	13.56	NA	16.65	1.88	1148	FALSE			FALSE		October 2(	13	Complete		TRUE	Decrease
31592	Cricotracheal r	Laryngoplasty	January 2016	09		AAOHNS	25.00	090-Day G	October 2(	090	25	NA	22.15	3.43	23	FALSE			FALSE		October 2(	13	Complete		TRUE	Decrease
31600	Tracheostomy,	Tracheostomy	April 2016	21		AAOHNS	5.56	CMS High	July 2015	000	5.56	NA	2.38	1.03	23498	FALSE			FALSE						TRUE	Increase
31601	Tracheostomy,	Tracheostomy	April 2016	21		AAOHNS	8.00	CMS High	July 2015	000	8	NA	3.93	1.10	4	FALSE			FALSE						TRUE	Increase
31603	Tracheostomy,	Tracheostomy	April 2016	21		AAOHNS	6.00	CMS High	July 2015	000	6	NA	2.34	1.03	801	FALSE			FALSE						TRUE	Increase
31605	Tracheostomy,	Tracheostomy	April 2016	21		AAOHNS	6.45	CMS High	July 2015	000	6.45	NA	2.02	1.26	278	FALSE			FALSE						TRUE	Increase
31610	Tracheostomy,	Tracheostomy	October 2016	15	RUC	AAOHNS, /	12.00	CMS High	July 2015	090	12	NA	14.66	1.76	1593	FALSE			FALSE						TRUE	Increase
31611	Construction o	Speech Prosthesis	February 2008	S		AAO-HNS	Reduce 99	Site of Ser	Septembe	090	6	NA	9.01	0.82	761	FALSE			FALSE						TRUE	PE Only
31620	Endobronchial	Endobronchial Ultra	January 2015	05		ACCP, ATS	Deleted fr	High Volur	April 2013							FALSE			TRUE	In January 2014, the RUC	October 2(	10	Complete		TRUE	Deleted from CPT
31622	Bronchoscopy,	Bronchial Aspiration	January 2015	05		ACCP, ATS	2.78	High Volur	April 2013	000	2.53	4.51	1.03	0.27	52315	FALSE			FALSE	In January 2014, the RUC	October 2(	10	Complete		TRUE	Maintain
31623	Bronchoscopy,	Diagnostic Bronchos	October 2017	09		ATS, CHES	2.63	High Volur	October 2(	000	2.63	5.36	1.01	0.21	26278	FALSE			FALSE						TRUE	Maintain
31624	Bronchoscopy,	Diagnostic Bronchos	October 2017	09		ATS, CHES	2.63	High Volur	October 2(	000	2.63	4.74	1.04	0.22	118565	FALSE			FALSE						TRUE	Maintain
31625	Bronchoscopy,	Endobronchial Ultra	January 2015	05		ATS, CHES	3.36	High Volur	April 2013	000	3.11	7.16	1.17	0.26	19149	FALSE			FALSE	In January 2014, the RUC	October 2(	10	Complete		TRUE	Maintain
31626	Bronchoscopy,	Endobronchial Ultra	January 2015	05		ACCP, ATS	4.16	High Volur	April 2013	000	3.91	21.01	1.42	0.43	2173	FALSE			FALSE	In January 2014, the RUC	October 2(	10	Complete		TRUE	Maintain
31628	Bronchoscopy,	Endobronchial Ultra	January 2015	05		ACCP, ATS	3.80	High Volur	April 2013	000	3.55	7.37	1.30	0.26	32291	FALSE			FALSE	In January 2014, the RUC	October 2(	10	Complete		TRUE	Maintain
31629	Bronchoscopy,	Endobronchial Ultra	January 2015	05		ACCP, ATS	4.00	High Volur	April 2013	000	3.75	9.78	1.36	0.31	13745	FALSE			FALSE	In January 2014, the RUC	October 2(	10	Complete		TRUE	Decrease
31632	Bronchoscopy,	Endobronchial Ultra	January 2015	05		ACCP, ATS	1.03	High Volur	April 2013	ZZZ	1.03	0.77	0.32	0.09	3890	FALSE			FALSE						TRUE	Maintain
31633	Bronchoscopy,	Endobronchial Ultra	January 2015	05		ACCP, ATS	1.32	High Volur	April 2013	ZZZ	1.32	0.93	0.42	0.11	1196	FALSE			FALSE						TRUE	Maintain
31645	Bronchoscopy,	Bronchial Aspiration	October 2016	08	RUC	ATS, CHES	2.88	Harvard V	October 2(	000	2.88	4.90	1.13	0.26	35233	FALSE			FALSE		May 2016	14	Complete		TRUE	Decrease
31646	Bronchoscopy,	Bronchial Aspiration	October 2016	08	RUC	ATS, CHES	2.78	Harvard V	October 2(	000	2.78	NA	1.09	0.25	4580	FALSE			FALSE		May 2016	14	Complete		TRUE	Increase
31652	Bronchoscopy,	Endobronchial Ultra	January 2015	05		ATS, ACCP	5.00	High Volur	October 2(	000	4.46	32.45	1.59	0.42	25507	FALSE			FALSE	In January 2014, the RUC	October 2(	10	Complete		TRUE	Decrease
31653	Bronchoscopy,	Endobronchial Ultra	January 2015	05		ATS, ACCP	5.50	High Volur	October 2(	000	4.96	33.33	1.74	0.45	13988	FALSE			FALSE	In January 2014, the RUC	October 2(	10	Complete		TRUE	Decrease
31654	Bronchoscopy,	Bronchial Aspiration	January 2015	05		ATS, ACCP	1.70	High Volur	October 2(	ZZZ	1.4	2.12	0.44	0.11	8214	FALSE			FALSE	In January 2014, the RUC	October 2(	10	Complete		TRUE	Decrease
32201	Pneumonosto	Drainage of Abscess	January 2013	04			Deleted fr	Codes Rep	January 2012							FALSE			FALSE	Deleted nine codes that c	October 2(	06	Complete		TRUE	Deleted from CPT
32405	Biopsy, lung or	Lung Biopsy-CT Guid	April 2019	05		ACR, SIR	Deleted fr	Codes Rep	October 2017						70068	FALSE			TRUE	In October 2017, maintair	February 2	11	complete		TRUE	Deleted from CPT
32408	Core needle bi	Lung Biopsy-CT Guid	April 2019	05		ACR, SIR	4.00	Codes Rep	April 2019	000	3.18	24.27	1.00	0.26		FALSE			FALSE						TRUE	Increase
32420	Pneumocentes	Thoracentesis with T	September 201	17		ACCP, ACR	Deleted fr	Harvard V	September 2011							FALSE			TRUE	In September 2011, the s	February 2	10	Complete		TRUE	Deleted from CPT
32421	Thoracentesis,	Thoracentesis with T	September 201	17		ACCP, ACR	Deleted fr	Harvard V	September 2011							FALSE			TRUE	In September 2011, the s	February 2	10	Complete		TRUE	Deleted from CPT
32422	Thoracentesis	Thoracentesis with T	September 201	17		ACCP, ACR	Deleted fr	Harvard V	April 2011							FALSE			TRUE	In September 2011, the s	February 2	10	Complete		TRUE	Deleted from CPT
32440	Removal of lur	RAW Review	January 2013	34		ACCP, ATS	No reliable	CMS Requ	November	090	27.28	NA	12.36	6.28	247	FALSE			FALSE						TRUE	Remove from screen
32480	Removal of lur	RAW Review	January 2013	34		ACCP, ATS	No reliable	CMS Requ	November	090	25.82	NA	11.53	5.93	4630	FALSE			FALSE						TRUE	Remove from Screen
32482	Removal of lur	RAW Review	January 2013	34		ACCP, ATS	No reliable	CMS Requ	November	090	27.44	NA	12.58	6.33	294	FALSE			FALSE						TRUE	Remove from Screen
32491	Removal of lur	RAW Review	January 2012	30		ACCP, ATS	Request fu	CMS Requ	November	090	25.24	NA	12.02	5.79	15	FALSE			FALSE						TRUE	Remove from Screen
32551	Tube thoracos	Chest Tube Thoraco	April 2012	10		ACCP, ATS	3.50	Harvard V	April 2011	000	3.04	NA	1.01	0.52	33044	FALSE			TRUE	In September 2011, the s	February 2	09	Complete		TRUE	Increase
32554	Thoracentesis,	Chest Tube Interven	October 2012	04		ACCP, ACR	1.82	Harvard V	October 2(	000	1.82	5.07	0.60	0.19	13649	FALSE			FALSE	4 new thoracentesis code	February 2	10	Complete		TRUE	Decrease
32555	Thoracentesis,	Chest Tube Interven	October 2012	04		ACCP, ACR	2.27	Harvard V	October 2(	000	2.27	7.14	0.75	0.20	229865	FALSE			FALSE	4 new thoracentesis code	February 2	10	Complete		TRUE	Decrease
32556	Pleural drainag	Chest Tube Interven	October 2012	04		ACCP, ACR	2.50	Harvard V	October 2(	000	2.5	19.31	0.80	0.30	3833	FALSE			FALSE	4 new thoracentesis code	February 2	10	Complete		TRUE	Decrease
32557	Pleural drainag	Chest Tube Interven	October 2012	04		ACCP, ACR	3.62	Harvard V	October 2(	000	3.12	16.44	0.98	0.26	38244	FALSE			FALSE	4 new thoracentesis code	February 2	10	Complete		TRUE	Decrease
32663	Thoracoscopy,	RAW review	January 2013	34		STS	No reliable	CMS Faste	October 2(	090	24.64	NA	10.61	5.67	9229	FALSE			FALSE						TRUE	Remove from Screen
33010	Pericardiocent	Pericardiocentesis a	January 2019	04			Deleted fr	Negative I'	September 2018						6698	FALSE			FALSE		Septembe 14		Complete		TRUE	Deleted from CPT
33011	Pericardiocent	Pericardiocentesis a	January 2019	04			Deleted fr	Negative I'	September 2018						87	FALSE			FALSE		Septembe 14		Complete		TRUE	Deleted from CPT
33015	Tube pericardi	Pericardiocentesis a	January 2019	04		ACC	Deleted fr	Negative I'	April 2017						1147	FALSE			TRUE	A RUC member requeste	Septembe 14		Complete		TRUE	Deleted from CPT
33016	Pericardiocent	Pericardiocentesis a	January 2019	04			5.00	Negative I'	Septembe	000	4.4	NA	1.55	0.94		FALSE			FALSE		Septembe 14		Complete		TRUE	Increase
33017	Pericardial dra	Pericardiocentesis a	January 2019	04			5.50	Negative I'	Septembe	000	4.62	NA	1.60	0.92		FALSE			FALSE		Septembe 14		Complete		TRUE	Increase
33018	Pericardial dra	Pericardiocentesis a	January 2019	04			6.00	Negative I'	Septembe	000	5.4	NA	1.72	0.99		FALSE			FALSE		Septembe 14		Complete		TRUE	Increase
33019	Pericardial dra	Pericardiocentesis a	January 2019	04			5.00	Negative I'	Septembe	000	4.29	NA	1.49	0.82		FALSE			FALSE		Septembe 14		Complete		TRUE	Increase
33020	Pericardiotom	Pericardiotomy	April 2018	10		AATS, STS	14.31	Negative I'	April 2018	090	14.31	NA	6.59	3.29	122	FALSE			TRUE	In April 2018, the specialt	May 2018	EC	Yes		TRUE	Decrease
33025	Creation of pe	Pericardiotomy	April 2018	10		AATS, STS	13.20	Negative I'	April 2017	090	13.2	NA	6.29	3.02	4535	FALSE			TRUE	In April 2018, the specialt	May 2018	EC	Yes		TRUE	Decrease
33207	Insertion of ne	Pacemaker or Pacing	April 2011	10		ACC	8.05	Codes Rep	February 2	090	7.8	NA	4.56	1.74	11733	FALSE			TRUE	33213 - This code, when	February 2	13	Complete		TRUE	Maintain
33208	Insertion of ne	Pacemaker or Pacing	April 2011	10		ACC	8.77	Codes Rep	February 2	090	8.52	NA	4.88	1.91	103628	FALSE			TRUE	33213 - This code, when	February 2	13	Complete		TRUE	Maintain

33212	Insertion of pa	Pacemaker or Pacing	September 201	04	ACC	5.26	Codes Rep	February 2	090	5.01	NA	3.37	1.12	317	FALSE			TRUE	33213 - This code, when (	February 2	13	Complete	TRUE	Decrease
33213	Insertion of pa	Pacemaker or Pacing	September 201	04	ACC	5.53	CMS Faste	October 2(	090	5.28	NA	3.43	1.18	1113	FALSE			TRUE	33213 - This code, when (	February 2	13	Complete	TRUE	Decrease
33221	Insertion of pa	Pacemaker or Pacing	September 201	04	ACC	5.80	Codes Rep	April 2011	090	5.55	NA	3.87	1.24	268	FALSE			FALSE		February 2	13		TRUE	Decrease
33227	Removal of pe	Pacemaker or Pacing	September 201	04	ACC	5.50	Codes Rep	April 2011	090	5.25	NA	3.56	1.17	3452	FALSE			FALSE		February 2	13		TRUE	Decrease
33228	Removal of pe	Pacemaker or Pacing	September 201	04	ACC	5.77	Codes Rep	April 2011	090	5.52	NA	3.68	1.25	24395	FALSE			FALSE		February 2	13		TRUE	Decrease
33229	Removal of pe	Pacemaker or Pacing	September 201	04	ACC	6.04	Codes Rep	April 2011	090	5.79	NA	3.96	1.30	5526	FALSE			FALSE		February 2	13		TRUE	Decrease
33230	Insertion of im	Pacemaker or Pacing	September 201	04	ACC	6.32	Codes Rep	April 2011	090	6.07	NA	3.86	1.37	140	FALSE			FALSE		February 2	13		TRUE	Decrease
33231	Insertion of im	Pacemaker or Pacing	September 201	04	ACC	6.59	Codes Rep	April 2011	090	6.34	NA	4.04	1.43	121	FALSE			FALSE		February 2	13		TRUE	Decrease
33233	Removal of pe	Pacemaker or Pacing	April 2011	10	ACC	3.39	Codes Rep	February 2	090	3.14	NA	3.01	0.71	8743	FALSE			TRUE	33213 - This code, when (	February 2	13	Complete	TRUE	Maintain
33240	Insertion of im	Pacemaker or Pacing	September 201	04	ACC	6.06	Codes Rep	February 2	090	5.8	NA	3.64	1.31	217	FALSE			TRUE	33213 - This code, when (	February 2	13	Complete	TRUE	Decrease
33241	Removal of im	Pacemaker or Pacing	April 2011	10	ACC	3.29	Codes Rep	February 2	090	3.04	NA	2.61	0.69	6043	FALSE			TRUE	33213 - This code, when (	February 2	13	Complete	TRUE	Maintain
33249	Insertion or re	Pacemaker or Pacing	April 2011	10	ACC	15.17	Codes Rep	February 2	090	14.92	NA	8.73	3.34	42661	FALSE			TRUE	33213 - This code, when (	February 2	13	Complete	TRUE	Maintain
33262	Removal of im	Pacemaker or Pacing	September 201	04	ACC	6.06	Codes Rep	April 2011	090	5.81	NA	3.90	1.30	3000	FALSE			FALSE		February 2	13		TRUE	Decrease
33263	Removal of im	Pacemaker or Pacing	September 201	04	ACC	6.33	Codes Rep	April 2011	090	6.08	NA	4.01	1.36	7980	FALSE			FALSE		February 2	13		TRUE	Decrease
33264	Removal of im	Pacemaker or Pacing	September 201	04	ACC	6.60	Codes Rep	April 2011	090	6.35	NA	4.17	1.44	11831	FALSE			FALSE		February 2	13		TRUE	Decrease
33282	Implantation o	Implantation and Re	April 2013	20		3.50	CMS Requ	October 2012							FALSE			FALSE		February 2	12	yes	TRUE	Decrease
33284	Removal of an	Implantation and Re	April 2013	20		3.00	CMS Requ	October 2012							FALSE			FALSE		February 2	12	yes	TRUE	Decrease
33405	Replacement,	Valve Replacement a	April 2012	40	STS	41.32	CMS High	Septembe	090	41.32	NA	15.58	9.42	17344	FALSE			FALSE					TRUE	Maintain
33430	Replacement,	Valve Replacement a	April 2012	40	STS	50.93	High IWPL	February 2	090	50.93	NA	19.29	11.59	7658	FALSE			FALSE					TRUE	Maintain
33533	Coronary arter	Valve Replacement a	April 2012	40	STS	34.98	CMS High	Septembe	090	33.75	NA	13.23	7.71	60180	FALSE			FALSE					TRUE	Increase
33620	Application of	New Technology Rev	January 2019	37	STS	CPT Article	New Techn	January 20	090	30	NA	11.30	6.87	56	TRUE	July 2016	Yes	FALSE					TRUE	Maintain
33621	Transthoracic i	New Technology Rev	January 2019	37	STS	CPT Article	New Techn	January 20	090	16.18	NA	7.30	3.73		TRUE	July 2016	Yes	FALSE					TRUE	Maintain
33622	Reconstructior	New Technology Rev	January 2019	37	STS	CPT Article	New Techn	January 20	090	64	NA	21.49	14.69	1	TRUE	July 2016	Yes	FALSE					TRUE	Maintain
33741	Transcatheter	Atrial Septostomy	January 2020	13		14.00	CMS Requ	Septembe	000	14	NA	4.98	3.12		FALSE			FALSE		Septembe	16	yes	TRUE	Maintain
33745	Transcatheter	Atrial Septostomy	January 2020	13		20.00	CMS Requ	Septembe	000	20	NA	7.24	3.96		FALSE			FALSE		Septembe	16	yes	TRUE	Maintain
33746	Transcatheter	Atrial Septostomy	January 2020	13		10.50	CMS Requ	Septembe	ZZZ	8	NA	2.88	1.45		FALSE			FALSE		Septembe	16	yes	TRUE	Maintain
33863	Ascending aor	Aortic Graft	February 2008	S	STS, AATS	Remove fr	High IWPL	February 2	090	58.79	NA	19.72	13.40	1812	FALSE			FALSE					TRUE	Remove from Screen
33945	Heart transpla	ECMO-ECLS	April 2014	11	STS, AAP, /	16.00	CMS Requ	November	090	89.5	NA	31.88	20.34	667	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33946	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	6.00	CMS Requ	November	XXX	6	NA	1.82	1.21	603	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33947	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	6.63	CMS Requ	November	XXX	6.63	NA	2.00	1.41	1395	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33948	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	4.73	CMS Requ	November	XXX	4.73	NA	1.49	0.75	4436	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33949	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	4.60	CMS Requ	November	XXX	4.6	NA	1.41	0.74	5342	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33951	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	8.15	CMS Requ	November	000	8.15	NA	2.36	1.84	1	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33952	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	8.43	CMS Requ	November	000	8.15	NA	2.56	1.76	1439	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33953	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	9.83	CMS Requ	November	000	9.11	NA	2.63	2.07		FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33954	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	9.43	CMS Requ	November	000	9.11	NA	2.74	2.04	354	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33956	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	16.00	CMS Requ	November	000	16	NA	4.73	3.63	352	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33957	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	4.00	CMS Requ	November	000	3.51	NA	1.08	0.78		FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33958	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	4.05	CMS Requ	November	000	3.51	NA	1.08	0.78	72	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33959	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	4.69	CMS Requ	November	000	4.47	NA	1.35	1.02		FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33960	Prolonged extr	ECMO-ECLS	April 2014	11	STS, AAP, /	Deleted fr	CMS Requ	July 2013							FALSE			TRUE	October 2013 the RUC re	February 2	23	Complete	TRUE	Deleted from CPT
33961	Prolonged extr	ECMO-ECLS	April 2014	11	STS, AAP, /	Deleted fr	CMS Requ	July 2013							FALSE			TRUE	October 2013 the RUC re	February 2	23	Complete	TRUE	Deleted from CPT
33962	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	4.73	CMS Requ	November	000	4.47	NA	1.35	1.02	20	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33963	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	9.00	CMS Requ	November	000	9	NA	2.60	2.04		FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33964	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	9.50	CMS Requ	November	000	9.5	NA	2.74	2.14	22	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33965	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	3.51	CMS Requ	November	000	3.51	NA	1.08	0.78		FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33966	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	4.50	CMS Requ	November	000	4.5	NA	1.44	0.97	383	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33969	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	6.00	CMS Requ	November	000	5.22	NA	1.56	1.18		FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33984	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	6.38	CMS Requ	November	000	5.46	NA	1.58	1.25	543	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33985	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	9.89	CMS Requ	November	000	9.89	NA	2.85	2.24	1	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33986	Extracorporeal	ECMO-ECLS	April 2014	11	STS, AAP, /	10.00	CMS Requ	November	000	10	NA	2.99	2.28	221	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33987	Arterial expos	ECMO-ECLS	April 2014	11	STS, AAP, /	4.08	CMS Requ	November	ZZZ	4.04	NA	1.13	0.93	41	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33988	Insertion of lef	ECMO-ECLS	April 2014	11	STS, AAP, /	15.00	CMS Requ	November	000	15	NA	4.28	3.41	40	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
33989	Removal of lef	ECMO-ECLS	April 2014	11	STS, AAP, /	9.50	CMS Requ	November	000	9.5	NA	2.74	2.14	14	FALSE			FALSE		February 2	23	Complete	TRUE	Maintain
34701	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	23.71	Codes Rep	January 20	090	23.71	NA	6.98	5.46	824	FALSE			FALSE					TRUE	Decrease
34702	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	36.00	Codes Rep	January 20	090	36	NA	9.51	8.40	99	FALSE			FALSE					TRUE	Decrease
34703	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	26.52	Codes Rep	January 20	090	26.52	NA	7.34	6.16	1118	FALSE			FALSE					TRUE	Decrease
34704	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	45.00	Codes Rep	January 20	090	45	NA	11.18	10.63	141	FALSE			FALSE					TRUE	Decrease
34705	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	29.58	Codes Rep	January 20	090	29.58	NA	8.07	6.86	13089	FALSE			FALSE					TRUE	Decrease
34706	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	45.00	Codes Rep	January 20	090	45	NA	11.45	10.52	641	FALSE			FALSE					TRUE	Decrease
34707	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	22.28	Codes Rep	January 20	090	22.28	NA	6.55	5.13	652	FALSE			FALSE					TRUE	Decrease
34708	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	36.50	Codes Rep	January 20	090	36.5	NA	8.89	8.52	85	FALSE			FALSE					TRUE	Decrease
34709	Placement of e	Endovascular Repair	January 2017	10	SVS, SIR, S	6.50	Codes Rep	January 20	ZZZ	6.5	NA	1.40	1.51	3632	FALSE			FALSE					TRUE	Decrease
34710	Delayed placer	Endovascular Repair	January 2017	10	SVS, SIR, S	15.00	Codes Rep	January 20	090	15	NA	4.80	3.43	1186	FALSE			FALSE					TRUE	Decrease
34711	Delayed placer	Endovascular Repair	January 2017	10	SVS, SIR, S	6.00	Codes Rep	January 20	ZZZ	6	NA	1.26	1.42	367	FALSE			FALSE					TRUE	Decrease
34712	Transcatheter	Endovascular Repair	January 2017	10	SVS, SIR, S	12.00	Codes Rep	January 20	090	12	NA	4.47	2.71	1214	FALSE			FALSE					TRUE	Decrease
34713	Percutaneous	Endovascular Repair	January 2017	10	SVS, SIR, S	2.50	Codes Rep	January 20	ZZZ	2.5	NA	0.53	0.59	16159	FALSE			FALSE					TRUE	Decrease
34714	Open femoral	Endovascular Repair	January 2017	10	SVS, SIR, S	5.25	Codes Rep	January 20	ZZZ	5.25	NA	1.40	1.21	487	FALSE			FALSE					TRUE	Decrease
34715	Open axillary/s	Endovascular Repair	January 2017	10	SVS, SIR, S	6.00	Codes Rep	January 20	ZZZ	6	NA	1.32	1.43	206	FALSE			FALSE					TRUE	Decrease
34716	Open axillary/s	Endovascular Repair	January 2017	10	SVS, SIR, S	7.19	Codes Rep	January 20	ZZZ	7.19	NA	2.00	1.63	798	FALSE			FALSE					TRUE	Decrease
34800	Endovascular r	Endovascular Repair	January 2017	10	AAOHNS	Deleted fr	Codes Rep	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
34802	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	Deleted fr	Pre-Time A	January 2014							FALSE			TRUE	Referred to CPT for revisi	September 2016		yes	TRUE	Deleted from CPT
34803	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	Deleted fr	Codes Rep	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
34804	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	Deleted fr	Codes Rep	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
34805	Endovascular r	Endovascular Repair	January 2017	10	SVS, SIR, S	Deleted fr	Codes Rep	January 2017							FALSE			FALSE					TRUE	Deleted from CPT
34806	Transcatheter	Endovascular Repair	January 2017	10	SVS, SIR, S	Deleted fr	Codes Rep	January 2017							FALSE			FALSE					TRUE	Deleted from CPT
34812	Open femoral	Endovascular Repair	January 2017	10	SVS, SIR, S	4.13	Pre-Time A	January 20	ZZZ	4.13	NA	0.90	0.98	9013	FALSE			TRUE	Referred to CPT for revisi	Septembe	27	yes	TRUE	Decrease
34820	Open iliac arte	Endovascular Repair	January 2017	10	SVS, SIR, S	7.00	Codes Rep	January 20	ZZZ	7	NA	1.44	1.67	82	FALSE			FALSE					TRUE	Decrease
34825	Placement of p	Endovascular Repair	January 2017	10	SVS, SIR, S	Deleted fr	Pre-Time A	January 2014							FALSE			TRUE	Referred to CPT for revisi	Septembe	27	yes	TRUE	Deleted from CPT
34826	Placement of p	Endovascular Repair	January 2017	10	SVS, SIR, S	Deleted fr	Codes Rep	January 2017							FALSE			FALSE					TRUE	Deleted from CPT

34833	Open iliac arte	Endovascular Repair	January 2017	10			SVS, SIR, S	8.16	Codes Rep	January 2(	ZZZ	8.16	NA	1.29	1.96	46	FALSE			FALSE					TRUE	Decrease
34834	Open brachial	Endovascular Repair	January 2017	10			SVS, SIR, S	2.65	Codes Rep	January 2(	ZZZ	2.65	NA	0.48	0.64	366	FALSE			FALSE					TRUE	Decrease
34900	Endovascular r	Endovascular Repair	January 2017	10			SVS, SIR, S	Deleted fr	Codes Rep	January 2017							FALSE			FALSE					TRUE	Deleted from CPT
35301	Thromboenda	Thromboendarterec	January 2013	21			SVS	21.16	CMS High	Septembe	090	21.16	NA	6.69	5.13	35904	FALSE			FALSE					TRUE	Increase
35450	Transluminal b	Open and Percutane	January 2016	15		RUC	ACR, SIR, S	Deleted fr	Codes Rep	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
35452	Transluminal b	Open and Percutane	January 2016	15		RUC	ACR, SIR, S	Deleted fr	Codes Rep	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
35454	Deleted from (	Endovascular Revas	April 2010	07			ACC, ACR,	Deleted fr	CMS Faste	February 2010							FALSE			FALSE		February 2	07		TRUE	Deleted from CPT
35456	Deleted from (	Endovascular Revas	April 2010	07			ACC, ACR,	Deleted fr	CMS Faste	February 2010							FALSE			FALSE		February 2	07		TRUE	Deleted from CPT
35458	Transluminal b	Open and Percutane	January 2016	15		RUC	ACR, SIR, S	Deleted fr	Codes Rep	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
35459	Deleted from (	Endovascular Revas	April 2010	07			ACC, ACR,	Deleted fr	CMS Faste	February 2010							FALSE			FALSE		February 2	07		TRUE	Deleted from CPT
35460	Transluminal b	Open and Percutane	January 2016	15		RUC	ACR, SIR, S	Deleted fr	Codes Rep	October 2015							FALSE			FALSE					TRUE	Deleted from CPT
35470	Deleted from (	Endovascular Revas	April 2010	07			ACC, ACR,	Deleted fr	CMS Faste	October 2008							FALSE			TRUE	The code is part of a com	February 2	07	Deleted- Ne	TRUE	Deleted from CPT
35471	Transluminal b	Open and Percutane	January 2016	15		RUC	ACR, SIR, S	Deleted fr	CMS Faste	October 2009							FALSE			TRUE	In January 2015, the Joint	October 2015		Deleted fro	TRUE	Deleted from CPT
35472	Transluminal b	Open and Percutane	January 2016	15		RUC	ACR, SIR, S	Deleted fr	CMS Faste	October 2009							FALSE			TRUE	The code is part of a com	Removed from CPT r		Complete	TRUE	Deleted from CPT
35473	Deleted from (	Endovascular Revas	April 2010	07			ACC, ACR,	Deleted fr	CMS Faste	February 2010							FALSE			TRUE	The code is part of a com	February 2	07	Deleted- Ne	TRUE	Deleted from CPT
35474	Deleted from (	Endovascular Revas	April 2010	07			ACC, ACR,	Deleted fr	CMS Faste	October 2008							FALSE			TRUE	The code is part of a com	February 2	07	Deleted- Ne	TRUE	Deleted from CPT
35475	Transluminal b	Open and Percutane	January 2016	15			ACR, SIR, S	Deleted fr	CMS Faste	September 2011							FALSE			TRUE	In January 2015, the Joint	October 2015		Deleted fro	TRUE	Deleted from CPT
35476	Transluminal b	Open and Percutane	January 2016	15		RUC	ACR, SIR, S	Deleted fr	CMS Faste	September 2011							FALSE			TRUE	In January 2015, the Joint	October 2015		Deleted fro	TRUE	Deleted from CPT
35490	Deleted from (	Endovascular Revas	April 2010	07			SIR, ACR, S	Deleted fr	High Volur	April 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Deleted- Ne	TRUE	Deleted from CPT
35491	Deleted from (	Endovascular Revas	April 2010	07			SIR, ACR, S	Deleted fr	High Volur	April 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Deleted- Ne	TRUE	Deleted from CPT
35492	Deleted from (	Endovascular Revas	April 2010	07			SIR, ACR, S	Deleted fr	High Volur	April 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Deleted- Ne	TRUE	Deleted from CPT
35493	Deleted from (	Endovascular Revas	April 2010	07			SIR, ACR, S	Deleted fr	High Volur	February 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Deleted- Ne	TRUE	Deleted from CPT
35494	Deleted from (	Endovascular Revas	April 2010	07			SIR, ACR, S	Deleted fr	High Volur	April 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Deleted- Ne	TRUE	Deleted from CPT
35495	Deleted from (	Endovascular Revas	April 2010	07			SIR, ACR, S	Deleted fr	High Volur	February 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Deleted- Ne	TRUE	Deleted from CPT
35701	Exploration no	Exploration of Artery	January 2019	06			ACS, SVS	7.50	Negative I'	January 2(	090	7.5	NA	4.08	1.25	823	FALSE			TRUE	The RUC identified CPT cc	Septembe	17	Complete	TRUE	Decrease
35702	Exploration no	Exploration of Artery	January 2019	06				7.12	Negative I'	Septembe	090	7.12	NA	3.38	1.55		FALSE			FALSE		Septembe	17	Complete	TRUE	Decrease
35703	Exploration no	Exploration of Artery	January 2019	06				7.50	Negative I'	Septembe	090	7.5	NA	3.00	1.74		FALSE			FALSE		Septembe	17	Complete	TRUE	Decrease
35721	Exploration (nc	Exploration of Artery	January 2019	06			ACS, SVS	Deleted fr	Negative I'	January 2018						484	FALSE			TRUE	The RUC identified CPT cc	Septembe	17	Complete	TRUE	Deleted from CPT
35741	Exploration (nc	Exploration of Artery	January 2019	06			ACS, SVS	Deleted fr	Negative I'	January 2018						199	FALSE			TRUE	The RUC identified CPT cc	Septembe	17	Complete	TRUE	Deleted from CPT
35761	Exploration (nc	Exploration of Artery	January 2019	06			ACS, SVS	Deleted fr	Negative I'	April 2017						1616	FALSE			TRUE	The RUC identified CPT cc	Septembe	17	Complete	TRUE	Deleted from CPT
36000	Introduction o	Introduction of Need	April 2010	45			ACC, AUR,	CMS consi	Harvard V	October 2(	XXX	0.18	0.67	0.07	0.01		FALSE			TRUE	The specialty societies indicated they could not			Complete	TRUE	Maintain
36010	Introduction o	Introduction of Cath	October 2013	18			ACR, SIR, S	Remove fr	Codes Rep	February 2	XXX	2.18	14.12	0.62	0.39	14377	FALSE			FALSE	The Workgroup accepts t	February 2	15		TRUE	Remove from screen
36140	Introduction o	Introduction of Need	October 2013	18			SVS, SIR, A	Remove fr	Harvard V	April 2011	XXX	1.76	13.35	0.49	0.36	20331	FALSE			FALSE					TRUE	Remove from Screen
36145	Deleted from (	Arteriovenous Shunt	April 2009	9				Deleted fr	Codes Rep	February 2008							FALSE			TRUE	Referred to the CPT Edito	February 2	31	Code Delete	TRUE	Deleted from CPT
36147	Introduction o	Dialysis Circuit -1	January 2016	14			ACR, RPA,	Deleted fr	Codes Rep	February 2008							FALSE			FALSE		October 2(	27	Complete	TRUE	Deleted from CPT
36148	Introduction o	Dialysis Circuit -1	January 2016	14			ACR, RPA,	Deleted fr	Codes Rep	February 2008							FALSE			FALSE		October 2(	27	Complete	TRUE	Deleted from CPT
36215	Selective cathe	Selective Catheter P	April 2016	23			ACR, RPA,	4.17	Codes Rep	February 2	000	4.17	28.04	1.44	0.54	45269	FALSE			TRUE	The Workgroup recommends the specialties su			Complete	TRUE	Decrease
36216	Selective cathe	Selective Catheter P	April 2016	23			ACR, SIR, S	5.27	Codes Rep	February 2	000	5.27	27.97	1.66	0.95	4580	FALSE			TRUE	The Workgroup recommends the specialties su			Complete	TRUE	Maintain
36217	Selective cathe	Selective Catheter P	April 2016	23			ACR, SIR, S	6.29	Harvard V	April 2011	000	6.29	49.17	1.98	1.25	4059	FALSE			TRUE	In September 2011, the specialty societies indic			Complete	TRUE	Maintain
36218	Selective cathe	Selective Catheter P	April 2016	23			ACR, SIR, S	1.01	CMS High	July 2015	ZZZ	1.01	5.35	0.30	0.15	1711	FALSE			FALSE					TRUE	Maintain
36221	Non-selective (	Cervicocerebral Ang	April 2012	14			AAN, AAN!	4.51	Codes Rep	February 2	000	3.92	27.05	1.08	0.84	2095	FALSE			TRUE	The Workgroup recomme	February 2	12	Complete	TRUE	Decrease
36222	Selective cathe	Cervicocerebral Ang	April 2012	14			AAN, AAN!	6.00	Codes Rep	February 2	000	5.28	31.56	1.77	1.21	7752	FALSE			TRUE	The Workgroup recomme	February 2	12	Complete	TRUE	Decrease
36223	Selective cathe	Cervicocerebral Ang	October 2020	24			AAN, AAN!	6.50	Codes Rep	February 2	000	5.75	42.78	2.20	1.39	29312	FALSE			TRUE	The Workgroup recomme	February 2	12	Complete	TRUE	Decrease
36224	Selective cathe	Cervicocerebral Ang	October 2020	24			AAN, AAN!	7.55	Codes Rep	February 2	000	6.25	55.63	2.68	1.62	36594	FALSE			TRUE	The Workgroup recomme	February 2	12	Complete	TRUE	Decrease
36225	Selective cathe	Cervicocerebral Ang	April 2012	14			AAN, AAN!	6.50	Codes Rep	February 2	000	5.75	40.17	2.13	1.41	11267	FALSE			TRUE	The Workgroup recomme	February 2	12	Complete	TRUE	Decrease
36226	Selective cathe	Cervicocerebral Ang	April 2012	14			AAN, AAN!	7.55	Codes Rep	February 2	000	6.25	52.87	2.61	1.58	32221	FALSE			TRUE	The Workgroup recomme	February 2	12	Complete	TRUE	Decrease
36227	Selective cathe	Cervicocerebral Ang	April 2012	14			AAN, AAN!	2.32	Codes Rep	February 2	ZZZ	2.09	4.66	0.83	0.52	13979	FALSE			TRUE	The Workgroup recomme	February 2	12	Complete	TRUE	Decrease
36228	Selective cathe	Cervicocerebral Ang	April 2012	14			AAN, AAN!	4.25	Codes Rep	February 2	ZZZ	4.25	34.39	1.71	1.12	2336	FALSE			TRUE	The Workgroup recomme	February 2	12	Complete	TRUE	Decrease
36245	Selective cathe	Selective Catheter P	January 2013	22			ACC, ACR,	4.90	Harvard V	October 2(	XXX	4.65	34.72	1.43	0.76	40259	FALSE			TRUE	An extensive lower extrer	February 2	07 & 06	New code s	TRUE	Decrease
36246	Selective cathe	Vascular Injection Pr	October 2012	27			SVS, SIR, A	5.27	Harvard V	February 2	000	5.02	20.12	1.35	0.99	36476	FALSE			FALSE					TRUE	Maintain
36247	Selective cathe	Vascular Injection Pr	October 2012	27			SVS, SIR, A	7.00	Harvard V	February 2	000	6.04	38.48	1.65	1.03	66061	FALSE			FALSE					TRUE	Increase
36248	Selective cathe	Catheter Placement	October 2009	40			ACR, SIR	Remove fr	CMS Faste	October 2(	ZZZ	1.01	2.71	0.28	0.13	26334	FALSE			TRUE	The code is part of a com	February 2	07	New code s	TRUE	Remove from Screen
36251	Selective cathe	Renal Angiography	April 2011	11			ACR, SIR	5.45	Codes Rep	February 2	000	5.1	35.66	1.51	0.86	3603	FALSE			FALSE					TRUE	Decrease
36252	Selective cathe	Renal Angiography	April 2011	11			ACR, SIR	7.38	Codes Rep	February 2	000	6.74	36.70	2.26	1.45	8044	FALSE			FALSE					TRUE	Decrease
36253	Superselective	Renal Angiography	April 2011	11			ACR, SIR	7.55	Codes Rep	February 2	000	7.3	57.15	2.15	0.81	1646	FALSE			FALSE					TRUE	Decrease
36254	Superselective	Renal Angiography	April 2011	11			ACR, SIR	8.15	Codes Rep	February 2	000	7.9	54.59	2.47	1.59	162	FALSE			FALSE					TRUE	Decrease
36410	Venipuncture,	Venipunture	April 2010	36			ACP	0.18	Harvard V	October 2(	XXX	0.18	0.31	0.07	0.02	155240	FALSE			FALSE					TRUE	Maintain
36475	Endovenous al	Endovenous Ablatio	April 2014	38			ACC, ACR,	5.30	High Volur	April 2013	000	5.3	31.36	1.73	1.10	109583	FALSE			FALSE					TRUE	Decrease
36476	Endovenous al	Endovenous Ablatio	April 2014	38			ACC, ACR,	2.65	High Volur	October 2(	ZZZ	2.65	5.77	0.72	0.54	7170	FALSE			FALSE					TRUE	Decrease
36478	Endovenous al	Endovenous Ablatio	April 2014	38			ACC, ACR,	5.30	High Volur	April 2013	000	5.3	25.42	1.76	1.02	61677	FALSE			FALSE					TRUE	Decrease
36479	Endovenous al	Endovenous Ablatio	April 2014	38			ACC, ACR,	2.65	High Volur	April 2013	ZZZ	2.65	6.26	0.78	0.52	6461	FALSE			FALSE					TRUE	Decrease
36481	Percutaneous	Interventional Radio	February 2009	21			ACR, SIR	New PE In	CMS Requ	NA	000	6.73	49.03	2.06	0.68	697	FALSE			FALSE					TRUE	PE Only
36511	Therapeutic ap	Therapeutic Aphere	January 2017	12			CAP, RPA	2.00. Refe	CMS Requ	January 2(	000	2	NA	1.06	0.14	235	TRUE	May 2018	yes	FALSE		Septembe	30	yes	TRUE	Increase
36512	Therapeutic ap	Therapeutic Aphere	January 2017	12			CAP, RPA	2.00. Refe	CMS Requ	January 2(	000	2	NA	1.00	0.13	2896	TRUE	May 2018	yes	FALSE		Septembe	30	yes	TRUE	Increase
36513	Therapeutic ap	Therapeutic Aphere	January 2017	12			CAP, RPA	2.00. Refe	CMS Requ	January 2(	000	2	NA	0.94	0.22	192	TRUE	May 2018	yes	FALSE		Septembe	30	yes	TRUE	Increase
36514	Therapeutic ap	Therapeutic Aphere	January 2017	12			CAP, RPA	1.81. Refe	CMS Requ	January 2(	000	1.81	17.01	0.79	0.15	28894	TRUE	May 2018	yes	FALSE		Septembe	30	yes	TRUE	Increase
36515	Therapeutic ap	Therapeutic Aphere	January 2017	12			CAP, RPA	Deleted fr	CMS Requ	January 2017							TRUE	May 2018	yes	FALSE		Septembe	30	yes	TRUE	Deleted from CPT
36516	Therapeutic ap	Therapeutic Aphere	January 2017	12			CAP, RPA	1.56. Refe	CMS Faste	October 2(	000	1.56	56.69	0.65	0.26	1069	TRUE	Sep 2009	Yes	TRUE	CPT code 36516 was iden	Septembe	30	yes	TRUE	Increase
36522	Photopheresis	Therapeutic Aphere	January 2017	12			CAP, RPA	1.75. Refe	CMS Requ	January 2(	000	1.75	48.78	0.97	0.13	8303	TRUE	May 2018	yes	FALSE		Septembe	30	yes	TRUE	Increase
36555	Insertion of no	Insertion of Catheter	October 2016	16		RUC	ACR, ASA	1.93	CMS High	July 2015	000	1.93	3.70	0.37	0.15	26	FALSE			FALSE					TRUE	Decrease
36556	Insertion of no	Insertion of Catheter	October 2016	16		RUC	ACR, ASA	1.75	CMS High	July 2015	000	1.75	4.60	0.50	0.21	409595	FALSE			FALSE					TRUE	Decrease
36568	Insertion of pe	PICC Line Procedure	January 2018	09	October 2(	RAW	ACR, SIR	2.11	Identified	October 2(	000	2.11	NA	0.34	0.21	3	FALSE			TRUE	In October 2016, The RU(	Septembe	16	Complete	TRUE	Decrease
36569	Insertion of pe	PICC Line Procedure	January 2018	09	October 2(	RAW	ACR, SIR	1.90. Revie	CMS High	July 2015	000	1.9	NA	0.61	0.21	14961	FALSE			TRUE	In October 2016, The RU(	Septembe	16	Complete	TRUE	Decrease
36572	Insertion of pe	PICC Line Procedure	January 2018	09	October 2(	RAW		2.00	CMS High	Septembe	000	1.82	11.35	0.65	0.17	25	FALSE			FALSE					TRUE	Decrease
36573	Insertion of pe	PICC Line Procedure	January 2018	09	October 2(	RAW		1.90	CMS High	Septembe	000	1.7	10.27	0.56	0.19	88728	FALSE			FALSE					TRUE	Decrease
36584	Replacement,	PICC Line Procedure	January 2018	09	October 2(	RAW	ACR, SIR	1.47	Identified	October 2(	000	1.2	9.21	0.41	0.13	4270	FALSE			TRUE	In October 2016, The RU(	Septembe	16	Complete	TRUE	Decrease
36620	Arterial cathet	Insertion of Catheter	April 2018	33			ACR, ASA	1.00	CMS High	July 2015	000	1	NA	0.20	0.09	581132	FALSE			FALSE					TRUE	Decrease
36818	Arteriovenous	Arteriovenous Anast	October 2013	10			ACS, SVS	13.00	CMS Requ	November	090	12.39	NA	4.81	2.95	5179	FALSE			FALSE					TRUE	Increase
36819	Arteriovenous	Arteriovenous Anast	October 2013	10			ACS, SVS	15.00	CMS Requ	November	090	13.29	NA	4.87	3.18	7456	FALSE			FALSE					TRUE	Increase
36820	Arteriovenous	Arteriovenous Anast	October 2013	10			ACS, SVS	13.99	Site of Ser	Septembe	090	13.07	NA	4.90	3.08	1343	FALSE			FALSE					TRUE	Decrease

36821	Arteriovenous	Arteriovenous Anast	October 2013	10				ACS, SVS	11.90	Site of Ser	Septembe	090	11.9	NA	4.61	2.84	30775	FALSE		FALSE							TRUE	Decrease		
36822	Insertion of ca	ECMO-ECLS	April 2014	11				STS, AAP, /	Deleted fr	CMS Requ	February	2011						FALSE		TRUE	Added as part of 33960 a		February 2	23	Complete	TRUE	Deleted from CPT		
36825	Creation of art	Arteriovenous Anast	October 2013	10				ACS, SVS	15.93	Site of Ser	Septembe	090	14.17	NA	5.66	3.41	1949	FALSE		FALSE							TRUE	Increase		
36830	Creation of art	Arteriovenous Anast	October 2013	10				ACS, SVS	11.90	CMS Requ	November	090	12.03	NA	4.56	2.87	20101	FALSE		FALSE							TRUE	Decrease		
36834	Deleted from (	Aneurysm Repair	September 200	16				AVA, ACS	Deleted fr	Site of Ser	September	2007						FALSE		TRUE	The RUC referred the ser		February 2	18	Code Delete	TRUE	Deleted from CPT		
36870	Thrombectom	Dialysis Circuit -1	January 2016	14			RUC	ACR, SIR, S	Deleted fr	Site of Ser	September	2007						FALSE		TRUE	The RUC reviewed the 20		October 2(	27	Complete	TRUE	Deleted from CPT		
36901	Introduction o	Dialysis Circuit -1	January 2016	14			RUC	ACR, RPA,	3.36	Codes Rep	October 2(	000	3.36	17.84	1.05	0.48	68183	FALSE		FALSE			October 2(	27	Complete	TRUE	Decrease		
36902	Introduction o	Dialysis Circuit -1	January 2016	14			RUC	ACR, RPA,	4.83	Codes Rep	October 2(	000	4.83	33.47	1.47	0.66	199617	FALSE		FALSE			October 2(	27	Complete	TRUE	Decrease		
36903	Introduction o	Dialysis Circuit -1	January 2016	14			RUC	ACR, RPA,	6.39	Codes Rep	October 2(	000	6.39	140.30	1.82	0.96	20847	FALSE		FALSE			October 2(	27	Complete	TRUE	Decrease		
36904	Percutaneous	Dialysis Circuit -1	January 2016	14			RUC	ACR, RPA,	7.50	Codes Rep	October 2(	000	7.5	48.72	2.16	1.03	4595	FALSE		FALSE			October 2(	27	Complete	TRUE	Decrease		
36905	Percutaneous	Dialysis Circuit -1	January 2016	14			RUC	ACR, RPA,	9.00	Codes Rep	October 2(	000	9	63.02	2.73	1.16	41205	FALSE		FALSE			October 2(	27	Complete	TRUE	Decrease		
36906	Percutaneous	Dialysis Circuit -1	January 2016	14			RUC	ACR, RPA,	10.42	Codes Rep	October 2(	000	10.42	173.18	3.02	1.41	14028	FALSE		FALSE			October 2(	27	Complete	TRUE	Decrease		
36907	Transluminal b	Dialysis Circuit -1	January 2016	14			RUC	ACR, RPA,	3.00	Codes Rep	October 2(	ZZZ	3	16.34	0.83	0.43	67888	FALSE		FALSE			October 2(	27	Complete	TRUE	Decrease		
36908	Transcatheter	Dialysis Circuit -1	January 2016	14			RUC	ACR, RPA,	4.25	Codes Rep	October 2(	ZZZ	4.25	49.50	1.13	0.64	5376	FALSE		FALSE			October 2(	27	Complete	TRUE	Decrease		
36909	Dialysis circuit	Dialysis Circuit -1	January 2016	14			RUC	ACR, RPA,	4.12	Codes Rep	October 2(	ZZZ	4.12	57.02	1.11	0.63	5424	FALSE		FALSE			October 2(	27	Complete	TRUE	Decrease		
37183	Revision of tra	Interventional Radio	February 2009	21				ACR, SIR	New PE in	CMS Requ	NA	000	7.74	180.49	2.36	0.69	893	FALSE		FALSE							TRUE	PE Only		
37191	Insertion of int	IVC Transcatheter P	April 2011	12				ACR, SIR, S	4.71	Codes Rep	February 2	000	4.46	63.97	1.38	0.61	25555	FALSE		FALSE			February 2	15		TRUE	Decrease		
37192	Repositioning	IVC Transcatheter P	April 2011	12				ACR, SIR, S	8.00	Codes Rep	February 2	000	7.1	31.60	1.20	1.72	32	FALSE		FALSE			February 2	15		TRUE	Decrease		
37193	Retrieval (rem	IVC Transcatheter P	April 2011	12				ACR, SIR, S	8.00	Codes Rep	February 2	000	7.1	39.56	2.01	0.96	7478	FALSE		FALSE			February 2	15		TRUE	Decrease		
37201	Transcatheter	Bundle Thrombolysi	April 2012	15				ACR, SIR, S	Deleted fr	Codes Rep	February 2	010						FALSE		TRUE	The Workgroup accepts t		October 2(	18	Complete	TRUE	Deleted from CPT		
37203	Transcatheter	Transcatheter Proce	September 201	07				ACC, ACR,	Deleted fr	Codes Rep	February 2	010						FALSE		TRUE			June 2011		Complete	TRUE	Deleted from CPT		
37204	Transcatheter	Embolization and Oc	April 2013	08				ACC, ACR,	Deleted fr	Codes Rep	February 2	010						FALSE		TRUE	In February 2010, the CPT		February 2	09	Complete	TRUE	Deleted from CPT		
37205	Transcatheter	Endovascular Revas	April 2010	07				SVS, ACS, S	Deleted fr	High Volur	February 2	010						FALSE		TRUE	In February 2010, the CPT		February 2	10	Complete	TRUE	Deleted from CPT		
37206	Transcatheter	Endovascular Revas	April 2010	07				SVS, ACS, S	Deleted fr	High Volur	February 2	010						FALSE		TRUE	In February 2010, the CPT		February 2	10	Complete	TRUE	Deleted from CPT		
37207	Transcatheter	Endovascular Revas	April 2010	07				SVS, ACS, S	Deleted fr	High Volur	February 2	010						FALSE		TRUE	In February 2010, the CPT		February 2	10	Complete	TRUE	Deleted from CPT		
37208	Transcatheter	Endovascular Revas	April 2010	07				SVS, ACS, S	Deleted fr	High Volur	February 2	010						FALSE		TRUE	In February 2010, the CPT		February 2	10	Complete	TRUE	Deleted from CPT		
37209	Exchange of a	Bundle Thrombolysi	April 2012	15				ACR, SIR, S	Deleted fr	Codes Rep	February 2	010						FALSE		TRUE	The Workgroup accepts t		October 2(	18	Complete	TRUE	Deleted from CPT		
37210	Uterine fibroid	Embolization and Oc	April 2013	08				ACR, SIR, S	Deleted fr	Codes Rep	February 2	010						FALSE		TRUE			February 2	09	Complete	TRUE	Deleted from CPT		
37211	Transcatheter	Bundle Thrombolysi	April 2012	15				ACR, SIR, S	8.00	Codes Rep	February 2	000	7.75	NA	2.10	1.36	10642	FALSE		FALSE							TRUE	Decrease		
37212	Transcatheter	Bundle Thrombolysi	April 2012	15				ACR, SIR, S	7.06	Codes Rep	February 2	000	6.81	NA	1.89	1.10	3012	FALSE		FALSE							TRUE	Decrease		
37213	Transcatheter	Bundle Thrombolysi	April 2012	15				ACR, SIR, S	5.00	Codes Rep	February 2	000	4.75	NA	1.25	0.74	2217	FALSE		FALSE							TRUE	Decrease		
37214	Transcatheter	Bundle Thrombolysi	April 2012	15				ACR, SIR, S	3.04	Codes Rep	February 2	000	2.49	NA	0.66	0.41	5963	FALSE		FALSE							TRUE	Decrease		
37220	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	000	7.9	74.19	2.01	1.74	12377	FALSE		TRUE	In October 2018, 37225, 3		February 2022			TRUE	Decrease		
37221	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	000	9.75	96.83	2.50	2.12	35798	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37222	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	ZZZ	3.73	16.14	0.84	0.81	3550	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37223	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	ZZZ	4.25	44.04	1.00	0.94	5293	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37224	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	000	8.75	88.47	2.29	1.90	34142	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37225	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	000	11.75	299.74	3.24	2.53	45496	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37226	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	000	10.24	273.20	2.63	2.26	24981	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37227	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	000	14.25	385.21	3.70	3.04	23176	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37228	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	000	10.75	128.91	2.71	2.29	34531	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37229	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	000	13.8	299.25	3.68	2.81	39373	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37230	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	000	13.55	284.04	3.81	2.91	2808	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37231	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	000	14.75	386.13	4.12	2.94	2320	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37232	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	ZZZ	4	23.55	1.01	0.79	14835	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37233	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	ZZZ	6.5	27.13	1.62	1.34	9241	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37234	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	ZZZ	5.5	111.73	1.62	1.18	343	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37235	Revascularizat	Endovascular Revas	January 2019	37	April 2022	RUC		SVS, ACS, S	Refer to CI	High Volur	February 2	ZZZ	7.8	116.61	2.24	1.42	100	FALSE		TRUE	In October 2018, 37225, 3		February 2022			FALSE	Decrease		
37236	Transcatheter	Transcatheter Place	April 2013	09				SVS, ACS, S	9.00	Codes Rep	February 2	000	8.75	84.52	2.32	1.81	13074	FALSE		FALSE			February 2	10	Complete	TRUE	Decrease		
37237	Transcatheter	Transcatheter Place	April 2013	09				SVS, ACS, S	4.25	Codes Rep	February 2	ZZZ	4.25	43.32	0.98	0.90	1497	FALSE		FALSE			February 2	10	Complete	TRUE	Decrease		
37238	Transcatheter	Transcatheter Place	April 2013	09				SVS, ACS, S	6.29	Codes Rep	February 2	000	6.04	106.77	1.72	1.17	10579	FALSE		FALSE			February 2	10	Complete	TRUE	Decrease		
37239	Transcatheter	Transcatheter Place	April 2013	09				SVS, ACS, S	3.34	Codes Rep	February 2	ZZZ	2.97	53.45	0.83	0.62	4688	FALSE		FALSE			February 2	10	Complete	TRUE	Decrease		
37241	Vascular embc	Embolization and Oc	April 2013	08				SVS, ACS, S	9.00	Codes Rep	February 2	000	8.75	137.81	2.50	1.30	1922	FALSE		FALSE			February 2	09		TRUE	Decrease		
37242	Vascular embc	Embolization and Oc	April 2013	08				SVS, ACS, S	11.98	Codes Rep	February 2	000	9.8	220.06	2.58	1.41	8635	FALSE		FALSE			February 2	09		TRUE	Decrease		
37243	Vascular embc	Embolization and Oc	April 2013	08				SVS, ACS, S	14.00	Codes Rep	February 2	000	11.74	271.90	3.36	1.04	14067	FALSE		FALSE			February 2	09		TRUE	Decrease		
37244	Vascular embc	Embolization and Oc	April 2013	08				SVS, ACS, S	14.00	Codes Rep	February 2	000	13.75	198.34	4.14	1.26	12731	FALSE		FALSE			February 2	09		TRUE	Decrease		
37246	Transluminal b	Open and Percutane	January 2016	15			RUC	ACR, SIR, S	7.00	Codes Rep	October 2(	000	7	51.34	1.87	1.21	8680	FALSE		FALSE			October 2(	24	Complete	TRUE	Decrease		
37247	Transluminal b	Open and Percutane	January 2016	15			RUC	ACR, SIR, S	3.50	Codes Rep	October 2(	ZZZ	3.5	14.34	0.73	0.70	760	FALSE		FALSE			October 2(	24	Complete	TRUE	Decrease		
37248	Transluminal b	Open and Percutane	January 2016	15			RUC	ACR, SIR, S	6.00	Codes Rep	October 2(	000	6	37.31	1.79	0.82	15577	FALSE		FALSE			October 2(	24	Complete	TRUE	Decrease		
37249	Transluminal b	Open and Percutane	January 2016	15			RUC	ACR, SIR, S	2.97	Codes Rep	October 2(	ZZZ	2.97	11.33	0.76	0.48	3865	FALSE		FALSE			October 2(	24	Complete	TRUE	Decrease		
37250	Intravascular u	Intravascular Ultrasc	January 2015	07				ACC, SCAI,	Deleted fr	Final Rule	July 2014							FALSE		TRUE	A CCP was submitted for		October 2(	13	Complete	TRUE	Deleted from CPT		
37251	Intravascular u	Intravascular Ultrasc	January 2015	07				ACC,SCAI,	Deleted fr	Final Rule	July 2014							FALSE		TRUE	A CCP was submitted for		October 2(	13	Complete	TRUE	Deleted from CPT		
37252	Intravascular u	Intravascular Ultrasc	October 2018	14				ACC,SCAI,	1.80	Final Rule	July 2014	ZZZ	1.8	30.84	0.45	0.36	60377	FALSE		FALSE	A CCP was submitted for		October 2(	13	Complete	TRUE	Decrease		
37253	Intravascular u	Intravascular Ultrasc	October 2018	14				ACC,SCAI,	1.44	Final Rule	July 2014	ZZZ	1.44	3.65	0.36	0.27	91408	FALSE		FALSE	A CCP was submitted for		October 2(	13	Complete	TRUE	Decrease		
37609	Ligation or bio	Ligation	September 200	16				SVS, ACS	Reduce 99	Site of Ser	Septembe	010	3.05	5.75	2.33	0.63	14539	FALSE		FALSE							TRUE	PE Only		
37619	Ligation of infe	Ligation of Inferior V	April 2011	13				ACS, SVS	37.60	Codes Rep	February 2	090	30	NA	13.67	7.33	33	FALSE		FALSE			February 2	15		TRUE	Increase		
37620	Interruption, p	Major Vein Revision	April 2010	45				ACR, SIR, S	Deleted fr	Codes Rep	February 2	010						FALSE		TRUE	The Workgroup accepts t		February 2	15	Code Delete	TRUE	Deleted from CPT		
37760	Ligation of per	Perorator Vein Ligat	April 2009	10				SVS, ACS	10.69	Site of Ser	Septembe	090	10.78	NA	5.01	2.53	65	FALSE		TRUE	The RUC referred the ser		February 2	19	Complete	TRUE	Maintain		
37761	Ligation of per	Perforator Vein Liga	April 2009	10				SVS, ACS	9.00	Site of Ser	April 2009	090	9.13	NA	4.43	2.12	350	FALSE		FALSE							TRUE	Increase		
37765	Stab phlebectc	Stab Phlebectomy of	April 2018	12				ACS, SIR, S	4.80	High Volur	February 2	010	4.8	7.22	2.08	1.03	14709	FALSE		FALSE							TRUE	Decrease		
37766	Stab phlebectc	Stab Phlebectomy of	April 2018	12				ACS, SIR, S	6.00	High Volur	February 2	010	6	7.92	2.42	1.25	11253	FALSE		FALSE							TRUE	Decrease		
37785	Ligation, divisi	Ligation	September 200	16				APMA, SV!	Reduce 99	Site of Ser	Septembe	090	3.93	5.80	2.69	0.91	934	FALSE		FALSE							TRUE	PE Only		
38220	Diagnostic bor	Diagnostic Bone Ma	April 2016	06				ASCO, ASH	1.20	CMS High	February 2	XXX	1.2	3.57	0.66	0.17	7044	FALSE		FALSE			February 2	16	Complete	TRUE	Decrease		
38221	Diagnostic bor	Diagnostic Bone Ma	April 2016	06				ASCO, ASH	1.28	CMS High	July 2015	XXX	1.28	3.37	0.66	0.09	12465	FALSE		TRUE	Prior to the January 2016		February 2	16	Complete	TRUE	Decrease		
38222	Diagnostic bor	Diagnostic Bone Ma	April 2016	06				ASCO, ASH	1.44	CMS High	February 2	XXX	1.44	3.65	0.69	0.11	120998	FALSE		FALSE			February 2	16	Complete	TRUE	Decrease		
38505	Biopsy or excis	Needle Biopsy of Lyr	October 2020	15				ACR, SIR	1.59	Harvard V	October 2(	000	1.14	2.36	0.77	0.11	33584	FALSE		FALSE							TRUE	Increase		
38542	Dissection, dee	Jugular Node Dissec	April 2008	40				ACS, AAO-	7.85	Site of Ser	Septembe	090	7.95	NA	5.90	1.30	571	FALSE		FALSE							TRUE	Increase		
38570	Laparoscopy, s	Laparoscopy Lymph	September 201	12				AUA	9.34	010-Day G	January 2(	010	8.49	NA	5.18	1.44	5714	FALSE		FALSE							TRUE	Maintain		
38571	Laparoscopy, s	Laparoscopy Lymph	September 201	12				AUA	12.00	CMS Faste	October 2(	010	12	NA	5.87	1.49	17981	FALSE		FALSE							TRUE	Decrease		
38572	Laparoscopy, s	Laparoscopy Lymph	September 201	12				ACOG	15.60	010-Day G	January 2(	010	15.6	NA	8.67	2.38	2251	FALSE		FALSE							TRUE	Decrease		

38792	Injection proce	Radioactive Tracer	January 2018	23				0.65	Negative I'	April 2017	000	0.65	1.72	0.23	0.09	33143	FALSE			FALSE						TRUE	Increase		
39400	Mediastinosco	Mediastinoscopy wi	January 2015	08			STS	Deleted fr	Pre-Time A	January 2014							FALSE			TRUE	Referred to CPT for revisi	October 2(	14	Complete		TRUE	Deleted from CPT		
39401	Mediastinosco	Mediastinoscopy wi	January 2015	08			STS	5.44	Pre-Time A	October 2(	000	5.44	NA	2.30	1.25	535	FALSE			FALSE	Referred to CPT for revisi	October 2(	14	Complete		TRUE	Decrease		
39402	Mediastinosco	Mediastinoscopy wi	January 2015	08			STS	7.50	Pre-Time A	October 2(	000	7.25	NA	2.87	1.65	4086	FALSE			FALSE	Referred to CPT for revisi	October 2(	14	Complete		TRUE	Increase		
40490	Biopsy of lip	Biopsy of Lip	September 201	21			AAO-HNS,	1.22	Harvard V	April 2011	000	1.22	2.34	0.68	0.13	32762	FALSE			FALSE						TRUE	Maintain		
40650	Repair lip, full	PE Subcommittee	April 2016	46			AAOS, ACE	PE Clinical	Emergent	October 2(	090	3.78	9.72	4.60	0.71	355	TRUE	Nov 2016	yes	FALSE						TRUE	PE Only		
40800	Drainage of ab	RAW	April 2014	52				Maintain	010-Day G	January 2(	010	1.23	4.87	2.19	0.13	2390	FALSE			FALSE						TRUE	Maintain		
40801	Drainage of ab	Ostectomy	January 2020	37			APMA, AA	Maintain.	Site of Ser	Septembe	010	2.63	5.88	2.97	0.25	1609	FALSE			FALSE						TRUE	PE Only		
40808	Biopsy, vestib	Biopsy of Mouth Les	April 2018	13			AAOHNS, /	1.05	Negative I'	April 2017	010	1.05	3.81	1.36	0.13	10517	FALSE			FALSE						TRUE	Increase		
40812	Excision of lesi	RAW	April 2014	52				Maintain	010-Day G	January 2(	010	2.37	5.96	2.85	0.25	5703	FALSE			FALSE						TRUE	Maintain		
40820	Destruction of	RAW	April 2014	52				Maintain	010-Day G	January 2(	010	1.34	6.47	3.54	0.14	1264	FALSE			FALSE						TRUE	Maintain		
41530	Submucosal at	Submucosal ablatior	April 2015	26	RUC		AAO-HNS	3.50	Final Rule	July 2014	000	3.5	25.25	7.42	0.47	350	FALSE			FALSE						TRUE	Decrease		
42145	Palatopharyng	Palatopharyngoplast	April 2008	41			AAO-HNS	9.63	Site of Ser	Septembe	090	9.78	NA	9.13	1.34	518	FALSE			FALSE						TRUE	Maintain		
42415	Excision of par	Excise Parotid Gland	February 2011	27			ACS, AAO-	18.12	Site of Ser	Septembe	090	17.16	NA	11.16	2.42	5439	FALSE			FALSE						TRUE	Maintain		
42420	Excision of par	Excise Parotid Gland	February 2011	27			ACS, AAO-	21.00	Site of Ser	Septembe	090	19.53	NA	12.21	2.75	1561	FALSE			FALSE						TRUE	Maintain		
42440	Excision of sub	Submandibular Glan	October 2010	64			AAO-HNS,	7.13	Site of Ser	Septembe	090	6.14	NA	5.06	0.86	1780	FALSE			FALSE						TRUE	Maintain		
43191	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	2.78	MPC List	Septembe	000	2.49	NA	1.65	0.36	2988	FALSE			FALSE						TRUE	Increase		
43192	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	3.21	MPC List	Septembe	000	2.79	NA	1.73	0.41	211	FALSE			FALSE						TRUE	Increase		
43193	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	3.36	MPC List	Septembe	000	2.79	NA	1.72	0.39	210	FALSE			FALSE						TRUE	Increase		
43194	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	3.99	MPC List	Septembe	000	3.51	NA	1.55	0.53	115	FALSE			FALSE						TRUE	Increase		
43195	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	3.21	MPC List	Septembe	000	3.07	NA	1.83	0.43	569	FALSE			FALSE						TRUE	Increase		
43196	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	3.36	MPC List	Septembe	000	3.31	NA	1.94	0.43	486	FALSE			FALSE						TRUE	Increase		
43197	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	1.59	MPC List	Septembe	000	1.52	4.07	0.65	0.23	1136	FALSE			FALSE						TRUE	Maintain		
43198	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	1.89	MPC List	Septembe	000	1.82	4.32	0.79	0.25	255	FALSE			FALSE						TRUE	Maintain		
43200	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	1.59	MPC List	Septembe	000	1.42	6.21	0.92	0.21	5390	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Maintain		
43201	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	1.90	MPC List	Septembe	000	1.72	5.78	1.04	0.23	220	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Decrease		
43202	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	1.89	MPC List	Septembe	000	1.72	8.94	1.05	0.22	2578	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Maintain		
43204	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	2.89	MPC List	Septembe	000	2.33	NA	1.35	0.25	13	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Decrease		
43205	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	3.00	MPC List	Septembe	000	2.44	NA	1.40	0.26	159	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Decrease		
43206	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	2.39	MPC List	Septembe	000	2.29	6.52	1.33	0.25	21	FALSE			FALSE						TRUE	Decrease		
43211	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	4.58	MPC List	Septembe	000	4.2	NA	2.17	0.45	99	FALSE			FALSE						TRUE	Decrease		
43212	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	3.73	MPC List	Septembe	000	3.4	NA	1.57	0.56	585	FALSE			FALSE						TRUE	Decrease		
43213	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	5.00	MPC List	Septembe	000	4.63	33.35	2.24	0.68	187	FALSE			FALSE						TRUE	Decrease		
43214	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	3.78	MPC List	Septembe	000	3.4	NA	1.78	0.43	215	FALSE			FALSE						TRUE	Decrease		
43215	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	2.60	MPC List	Septembe	000	2.44	9.30	1.33	0.34	989	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Maintain		
43216	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	2.40	MPC List	Septembe	000	2.3	10.01	1.33	0.26	195	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Maintain		
43217	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	2.90	MPC List	Septembe	000	2.8	9.72	1.56	0.30	53	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Maintain		
43219	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	Deleted fr	MPC List	September 2011							FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Deleted from CPT		
43220	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	2.10	MPC List	Septembe	000	2	27.96	1.18	0.26	2069	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Maintain		
43226	Esophagoscop	Esophagoscopy	October 2012	10			AAO-HNS,	2.34	MPC List	Septembe	000	2.24	8.98	1.23	0.33	1841	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Maintain		
43227	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	3.26	MPC List	Septembe	000	2.89	15.89	1.58	0.33	191	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Decrease		
43228	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	Deleted fr	MPC List	September 2011							FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Deleted from CPT		
43229	Esophagoscop	Esophagoscopy	October 2012	10			AGA, ASGE	3.72	MPC List	Septembe	000	3.49	18.25	1.83	0.42	2331	FALSE			FALSE						TRUE	Decrease		
43231	Esophagoscop	Esophagoscopy	April 2013	10			AGA, ASGE	3.19	MPC List	Septembe	000	2.8	NA	1.55	0.28	502	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Maintain		
43232	Esophagoscop	Esophagoscopy	April 2013	10			AGA, ASGE	3.83	MPC List	Septembe	000	3.59	NA	1.83	0.37	435	FALSE			FALSE	Several specific codes ide	May 2012				TRUE	Decrease		
43233	Esophagogastr	EGD	January 2013	08			AGA, ASGE	4.45	MPC List	October 2(	000	4.07	NA	2.03	0.59	1577	FALSE			FALSE		October 2(	14	Complete		TRUE	Decrease		
43234	Upper gastroir	Esophagoscopy	April 2013	10			AGA, ASGE	Deleted fr	MPC List	September 2011							FALSE			TRUE	Several specific codes ide	February 2	11	Complete		TRUE	Deleted from CPT		
43235	Esophagogastr	EGD	January 2013	08			AGA, ASGE	2.26	MPC List /	October 2(	000	2.09	6.59	1.23	0.25	323621	FALSE			FALSE	Several specific codes ide	October 2(	14	Complete		TRUE	Decrease		
43236	Esophagogastr	EGD	January 2013	08			AGA, ASGE	2.57	CMS Faste	October 2(	000	2.39	9.43	1.37	0.26	16281	TRUE	Apr 2009	Yes	FALSE	Several specific codes ide	October 2(	14	Complete		TRUE	Decrease		
43237	Esophagogastr	EGD	April 2013	11			AGA, ASGE	3.85	MPC List	Septembe	000	3.47	NA	1.85	0.37	18922	FALSE			TRUE	In the Panel Action memc	February 2	12	Complete		TRUE	Decrease		
43238	Esophagogastr	EGD	April 2013	11			AGA, ASGE	4.50	MPC List	Septembe	000	4.16	NA	2.15	0.45	14141	FALSE			TRUE	In the Panel Action memc	February 2	12	Complete		TRUE	Decrease		
43239	Esophagogastr	EGD with Biopsy	April 2019	12			ACG, ACS,	2.39	MPC List /	October 2(	000	2.39	8.84	1.37	0.26	1424058	FALSE			FALSE	Several specific codes identified by CMS through the MPC L					TRUE	Maintain		
43240	Esophagogastr	EGD	April 2013	11			AGA, ASGE	7.25	MPC List	Septembe	000	7.15	NA	3.48	0.76	1002	FALSE			TRUE	In the Panel Action memc	February 2	12	Complete		TRUE	Increase		
43241	Esophagogastr	EGD	January 2013	08			AGA, ASGE	2.59	MPC List	Septembe	000	2.49	NA	1.36	0.28	4312	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Maintain		
43242	Esophagogastr	EGD	April 2013	11			AGA, ASGE	5.39	CMS Faste	October 2(	000	4.73	NA	2.41	0.49	26340	TRUE	Mar 2009	Yes	TRUE	In the Panel Action memc	February 2	12	Complete		TRUE	Decrease		
43243	Esophagogastr	EGD	January 2013	08			AGA, ASGE	4.37	MPC List	Septembe	000	4.27	NA	2.14	0.48	647	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Decrease		
43244	Esophagogastr	EGD	January 2013	08			AGA, ASGE	4.50	MPC List	Septembe	000	4.4	NA	2.26	0.46	22233	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Decrease		
43245	Esophagogastr	EGD	January 2013	08			AGA, ASGE	3.18	MPC List	Septembe	000	3.08	15.04	1.64	0.42	15047	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Maintain		
43246	Esophagogastr	EGD	April 2013	11			AGA, ASGE	4.32	MPC List	Septembe	000	3.56	NA	1.78	0.49	71081	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Maintain		
43247	Esophagogastr	EGD	January 2013	08			AGA, ASGE	3.27	MPC List	Septembe	000	3.11	8.12	1.67	0.37	28637	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Decrease		
43248	Esophagogastr	EGD	January 2013	08			AGA, ASGE	3.01	MPC List	Septembe	000	2.91	9.18	1.60	0.32	110879	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Decrease		
43249	Esophagogastr	EGD	January 2013	08			AGA, ASGE	2.77	MPC List	Septembe	000	2.67	31.47	1.49	0.31	125878	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Decrease		
43250	Esophagogastr	EGD	January 2013	08			AGA, ASGE	3.07	MPC List	Septembe	000	2.97	10.44	1.58	0.43	3775	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Decrease		
43251	Esophagogastr	EGD	April 2013	11			AGA, ASGE	3.57	MPC List	Septembe	000	3.47	11.28	1.84	0.39	35888	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Decrease		
43253	Esophagogastr	EGD	April 2013	11			AGA, ASGE	5.39	MPC List	February 2	000	4.73	NA	2.41	0.49	2309	FALSE			TRUE	In the Panel Action memc	February 2	12	Complete		TRUE	Decrease		
43254	Esophagogastr	EGD	January 2013	08			AGA, ASGE	5.25	MPC List	October 2(	000	4.87	NA	2.46	0.52	5797	FALSE			FALSE		October 2(	14	Complete		TRUE	Decrease		
43255	Esophagogastr	EGD	January 2013	08			AGA, ASGE	4.20	MPC List	Septembe	000	3.56	16.12	1.88	0.39	62091	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Decrease		
43256	Upper gastroir	EGD	January 2013	08			AGA, ASGE	Deleted fr	MPC List	September 2011							FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Deleted from CPT		
43257	Esophagogastr	EGD	January 2013	08			AGA, ASGE	4.25	MPC List	Septembe	000	4.15	NA	2.11	0.49	148	FALSE			FALSE	Several specific codes ide	October 2012				TRUE	Decrease		
43258	Upper gastroir	EGD	January 2013	08			AGA, ASGE	Deleted fr	MPC List	September 2011							FALSE			FALSE	Several specific codes ide	October 2(	14	Complete		TRUE	Deleted from CPT		
43259	Esophagogastr	EGD	April 2013	11			AGA, ASGE	4.74	CMS Faste	October 2(	000	4.04	NA	2.10	0.43	34294	TRUE	Mar 2009	Yes	TRUE	In the Panel Action memc	February 2	12	Complete		TRUE	Decrease		
43260	Endoscopic ret	ERCP	April 2013	12			AGA, ASGE	5.95	MPC List	Septembe	000	5.85	NA	2.90	0.63	4795	FALSE			TRUE	Several specific codes ide	February 2	13	Complete		TRUE	Maintain		
43261	Endoscopic ret	ERCP	April 2013	12			AGA, ASGE	6.25	MPC List	Septembe	000	6.15	NA	3.04	0.65	7154	FALSE			FALSE	Several specific codes ide	January 2(	13			TRUE	Decrease		
43262	Endoscopic ret	ERCP	April 2013	12			AGA, ASGE	6.60	MPC List	Septembe	000	6.5	NA	3.19	0.70	30450	FALSE			FALSE	Several specific codes ide	January 2(	13			TRUE	Decrease		
43263	Endoscopic ret	ERCP	April 2013	12			AGA, ASGE	7.28	MPC List	Septembe	000	6.5	NA	3.15	0.74	67	FALSE			FALSE	Several specific codes ide	February 2	13			TRUE	Maintain		
43264	Endoscopic ret	ERCP	April 2013	12			AGA, ASGE	6.73	Harvard V	April 2011	000	6.63	NA	3.25	0.71	56121	FALSE			FALSE	Several specific codes ide	February 2	13			TRUE	Decrease		
43265	Endoscopic ret	ERCP	April 2013	12			AGA, ASGE	8.03	MPC List	Septembe	000	7.93	NA	3.83	0.85	2820	FALSE			FALSE	Several specific codes ide	February 2	13			TRUE	Decrease		
43266	Esophagogastr	EGD	January 2013	08			AGA, ASGE	4.40	MPC List	October 2(	000	3.92	NA	1.93	0.48	5767	FALSE			FALSE		October 2(	14	Complete		TRUE	Decrease		
43267	Endoscopic ret	ERCP	April 2013	12			AGA, ASGE	Deleted fr	MPC List	September 2011							FALSE			FALSE	Several specific codes ide	February 2	13			TRUE	Deleted from CPT		
43268	Endoscopic ret	ERCP	April 2013	12			AGA, ASGE	Deleted fr	Harvard V	April 2011							FALSE			FALSE	Several specific codes ide	February 2	13			TRUE	Deleted from CPT		

43269	Endoscopic ret	ERCP	April 2013	12		AGA, ASGE	Deleted fr	MPC List	September 2011								FALSE		FALSE	Several specific codes ide	February 2013			TRUE	Deleted from CPT
43270	Esophagogastr	EGD	January 2013	08		AGA, ASGE	4.39	MPC List	October 2000	4.01	18.21	2.08	0.44	20628	FALSE		FALSE		October 2014	Complete	TRUE	Decrease
43271	Endoscopic ret	ERCP	April 2013	12		AGA, ASGE	Deleted fr	MPC List	September 2011								FALSE		FALSE	Several specific codes ide	February 2013			TRUE	Deleted from CPT
43272	Endoscopic ret	ERCP	April 2013	12		AGA, ASGE	Deleted fr	MPC List	September 2011								FALSE		FALSE	Several specific codes ide	February 2013			TRUE	Deleted from CPT
43273	Endoscopic ca	ERCP	April 2013	12		AGA, ASGE	2.24	MPC List	Septembe ZZZ	2.24	NA	1.00	0.25	8668	FALSE		FALSE	Several specific codes ide	February 2013			TRUE	Maintain
43274	Endoscopic ret	ERCP	April 2013	12		AGA, ASGE	8.74	MPC List	Septembe 000	8.48	NA	4.07	0.92	43064	FALSE		FALSE		February 2013			TRUE	Decrease
43275	Endoscopic ret	ERCP	April 2013	12		AGA, ASGE	6.96	MPC List	Septembe 000	6.86	NA	3.35	0.74	14287	FALSE		FALSE		February 2013			TRUE	Decrease
43276	Endoscopic ret	ERCP	April 2013	12		AGA, ASGE	9.10	MPC List	Septembe 000	8.84	NA	4.24	0.94	16434	FALSE		FALSE		February 2013			TRUE	Decrease
43277	Endoscopic ret	ERCP	April 2013	12		AGA, ASGE	7.11	MPC List	Septembe 000	6.9	NA	3.37	0.74	6694	FALSE		FALSE		February 2013			TRUE	Decrease
43278	Endoscopic ret	ERCP	April 2013	12		AGA, ASGE	8.08	MPC List	Septembe 000	7.92	NA	3.81	0.85	600	FALSE		FALSE		February 2013			TRUE	Decrease
43450	Dilation of eso	Dilation of Esophagu	October 2012	17		AGA, ASGE	1.30	MPC List	Septembe 000	1.28	4.18	0.88	0.15	71670	FALSE		FALSE					TRUE	Decrease
43453	Dilation of eso	Dilation of Esophagu	October 2012	17		AGA, ASGE	1.51	MPC List	Septembe 000	1.41	25.10	0.93	0.16	1698	FALSE		FALSE	Several specific codes ide	May 2012			TRUE	Maintain
43456	Dilation of eso	Dilation of Esophagu	October 2012	17		AGA, ASGE	Deleted fr	MPC List	September 2011						FALSE		FALSE	Several specific codes ide	October 2014	Complete		TRUE	Deleted from CPT
43458	Dilation of eso	Dilation of Esophagu	October 2012	17		AGA, ASGE	Deleted fr	MPC List	September 2011						FALSE		FALSE	Several specific codes ide	October 2014	Complete		TRUE	Deleted from CPT
43760	Change of gast	Gastrostomy Tube R	January 2018	11		ACEP, ACG	Deleted fr	CMS 000-D	July 2016						FALSE		TRUE	In April 2017, the RUC no	Septembe 18	Complete		TRUE	Deleted from CPT
43762	Replacement c	Gastrostomy Tube R	January 2018	11	January 20	RAW	ACEP, ACG	0.75. Flag	CMS 000-D	Septembe 000	0.75	6.23	0.23	0.13	49049	FALSE		FALSE					TRUE	Decrease
43763	Replacement c	Gastrostomy Tube R	January 2018	11	January 20	RAW	ACEP, ACG	1.41. Flag	CMS 000-D	Septembe 000	1.41	9.02	0.81	0.25	1711	FALSE		FALSE					TRUE	Decrease
44143	Colectomy, pa	RAW	January 2016	54			99214 visit	High Level	October 2090		27.79	NA	14.94	6.28	10216	FALSE		FALSE					TRUE	Remove from screen
44205	Laparoscopy, s	Laproscopic Proced	October 2008	26		ACS, ASCR	Remove fr	CMS Faste	October 2090		22.95	NA	11.62	4.64	12383	FALSE		FALSE					TRUE	Remove from Screen
44207	Laparoscopy, s	Laproscopic Proced	October 2008	26		ACS, ASCR	Remove fr	CMS Faste	February 2090		31.92	NA	15.07	6.16	9951	FALSE		FALSE					TRUE	Remove from Screen
44380	Ileoscopy, thrc	Ileoscopy	Ileoscopy	October 2013	04		AGA, ASGE	0.97	MPC List	Septembe 000	0.87	4.95	0.67	0.10	2038	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
44381	Ileoscopy, thrc	Ileoscopy		October 2013	04		AGA, ASGE	1.48	MPC List	May 2013 000	1.38	29.46	0.88	0.17	150	FALSE		FALSE		May 2013	Complete		TRUE	Decrease
44382	Ileoscopy, thrc	Ileoscopy	Ileoscopy	October 2013	04		AGA, ASGE	1.27	MPC List	Septembe 000	1.17	7.87	0.83	0.14	1549	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Maintain
44383	Ileoscopy, thrc	Ileoscopy		October 2013	04		AGA, ASGE	Deleted fr	MPC List	September 2011						FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Deleted from CPT
44384	Ileoscopy, thrc	Ileoscopy		October 2013	04		AGA, ASGE	3.11	MPC List	May 2013 000	2.85	NA	1.30	0.34	124	FALSE		FALSE		May 2013	Complete		TRUE	Decrease
44385	Endoscopic ev	Pouchoscopy		October 2013	05		ACG, ACS,	1.30	MPC List	Septembe 000	1.2	5.09	0.74	0.15	1312	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
44386	Endoscopic ev	Pouchoscopy		October 2013	05		ACG, ACS,	1.60	MPC List	Septembe 000	1.5	7.87	0.91	0.17	1832	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
44388	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	2.82	MPC List	Septembe 000	2.72	6.39	1.45	0.39	4180	FALSE		TRUE	Several specific codes ide	October 2017	Complete		TRUE	Maintain
44389	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	3.12	MPC List	Septembe 000	3.02	9.13	1.61	0.38	2551	FALSE		TRUE	Several specific codes ide	October 2017	Complete		TRUE	Decrease
44390	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	3.82	MPC List	Septembe 000	3.74	8.05	1.97	0.41	18	FALSE		TRUE	Several specific codes ide	October 2017	Complete		TRUE	Maintain
44391	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	4.22	MPC List	Septembe 000	4.12	15.88	2.12	0.46	159	FALSE		TRUE	Several specific codes ide	October 2017	Complete		TRUE	Decrease
44392	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	3.63	MPC List	Septembe 000	3.53	7.58	1.76	0.49	297	FALSE		TRUE	Several specific codes ide	October 2017	Complete		TRUE	Decrease
44393	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	Deleted fr	MPC List	September 2011						FALSE		TRUE	Several specific codes ide	October 2017	Complete		TRUE	Deleted from CPT
44394	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	4.13	MPC List	Septembe 000	4.03	8.72	2.03	0.49	2081	FALSE		TRUE	Several specific codes ide	October 2017	Complete		TRUE	Decrease
44397	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	Deleted fr	MPC List	September 2011						FALSE		TRUE	Several specific codes ide	October 2017	Complete		TRUE	Deleted from CPT
44401	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	4.44	MPC List	Septembe 000	4.34	77.43	2.24	0.46	65	FALSE		TRUE		October 2017	Complete		TRUE	Decrease
44402	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	4.96	MPC List	January 20000	4.7	NA	2.40	0.49	4	FALSE		FALSE		October 2017	Complete		TRUE	Decrease
44403	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	5.81	MPC List	January 20000	5.5	NA	2.75	0.59	76	FALSE		TRUE		October 2017	Complete		TRUE	Decrease
44404	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	3.13	MPC List	January 20000	3.02	9.22	1.61	0.37	190	FALSE		TRUE		October 2017	Complete		TRUE	Decrease
44405	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	3.33	MPC List	January 20000	3.23	13.75	1.75	0.34	57	FALSE		TRUE		October 2017	Complete		TRUE	Decrease
44406	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	4.41	MPC List	January 20000	4.1	NA	2.13	0.44	4	FALSE		TRUE		October 2017	Complete		TRUE	Decrease
44407	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	5.06	MPC List	January 20000	4.96	NA	2.51	0.53		FALSE		TRUE		October 2017	Complete		TRUE	Decrease
44408	Colonoscopy tl	Colonoscopy throug	January 2014	08		ASCRS, AC	4.24	MPC List	January 20000	4.14	NA	2.15	0.45	76	FALSE		TRUE		October 2017	Complete		TRUE	Decrease
44901	Incision and dr	Drainage of Abscess	January 2013	04			Deleted fr	Codes Rep	January 2012						FALSE		FALSE	Deleted nine codes that c	October 2006	Complete		TRUE	Deleted from CPT
44970	Laparoscopy, s	Laproscopic Proced	October 2008	26		ACS	Remove fr	CMS Faste	October 2090		9.45	NA	6.13	2.24	22448	FALSE		FALSE					TRUE	Remove from Screen
45170	Deleted from (	Rectal Tumor Excisic	February 2009	11		ACS, ASCR	Deleted fr	Site of Ser	September 2007						FALSE		TRUE	CPT code 45170 Excision	October 2018	Code Delete		TRUE	Deleted from CPT
45171	Excision of rec	Rectal Tumor Excisic	February 2009	11		ACS, ASCR	8.00	Site of Ser	Septembe 090	8.13	NA	8.72	1.49	2516	FALSE		FALSE					TRUE	Decrease
45172	Excision of rec	Rectal Tumor Excisic	February 2009	11		ACS, ASCR	12.00	Site of Ser	Septembe 090	12.13	NA	10.18	2.05	1918	FALSE		FALSE					TRUE	Decrease
45300	Proctosigmoid	Diagnostic Proctosig	April 2017	13		ACS, ASCR	0.80	CMS 000-D	July 2016 000	0.8	2.99	0.48	0.13	23267	FALSE		FALSE					TRUE	Maintain
45330	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	0.84	Harvard Va	April 2011 000	0.84	4.65	0.67	0.11	50795	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
45331	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	1.14	MPC List	Septembe 000	1.14	7.50	0.81	0.14	36318	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
45332	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	1.85	MPC List	Septembe 000	1.76	6.40	1.07	0.22	353	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
45333	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	1.65	MPC List	Septembe 000	1.55	8.32	0.97	0.21	734	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
45334	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	2.10	MPC List	Septembe 000	2	13.83	1.19	0.22	3411	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
45335	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	1.15	MPC List	Septembe 000	1.04	7.61	0.76	0.14	3141	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
45337	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	2.20	MPC List	Septembe 000	2.1	NA	0.99	0.26	1691	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
45338	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	2.15	MPC List	Septembe 000	2.05	6.77	1.20	0.25	5383	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
45339	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	Deleted fr	MPC List	September 2011						FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Deleted from CPT
45340	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	1.35	MPC List	Septembe 000	1.25	12.98	0.85	0.16	1316	FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Decrease
45341	Sigmoidoscop	Flexible Sigmoidosc	January 2014	09		AGA, ASGE	2.43	MPC List	Septembe 000	2.12	NA	1.25	0.23	2713	FALSE		TRUE	Several specific codes ide	October 2016	Complete		TRUE	Increase
45342	Sigmoidoscop	Flexible Sigmoidosc	January 2014	09		AGA, ASGE	3.08	MPC List	Septembe 000	2.98	NA	1.64	0.32	374	FALSE		TRUE	Several specific codes ide	October 2016	Complete		TRUE	Decrease
45345	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	Deleted fr	MPC List	September 2011						FALSE		FALSE	Several specific codes ide	May 2013	Complete		TRUE	Deleted from CPT
45346	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	2.97	MPC List	May 2013 000	2.81	76.84	1.54	0.32	1183	FALSE		FALSE		May 2013	Complete		TRUE	Decrease
45347	Sigmoidoscop	Flexible Sigmoidosc	October 2013	06		ACG, ACS,	2.98	MPC List	May 2013 000	2.72	NA	1.47	0.30	637	FALSE		FALSE		May 2013	Complete		TRUE	Decrease
45349	Sigmoidoscop	Flexible Sigmoidosc	April 2014	13		AGA, ASGE	3.83	MPC List	January 20000	3.52	NA	1.86	0.39	632	FALSE		TRUE		October 2016	Complete		TRUE	Decrease
45350	Sigmoidoscop	Flexible Sigmoidosc	April 2014	13		AGA, ASGE	1.78	MPC List	January 20000	1.68	18.66	1.04	0.21	1214	FALSE		TRUE		October 2016	Complete		TRUE	Decrease
45355	Colonoscopy, r	Colonoscopy via sto	January 2014	08		AGA, ASGE	Deleted fr	MPC List	September 2011						FALSE		FALSE	Several specific codes ide	February 2032	Complete		TRUE	Deleted from CPT
45378	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	3.36	CMS High	Septembe 000	3.26	6.56	1.73	0.41	345987	FALSE		TRUE	Several specific codes ide	October 2018	Complete		TRUE	Decrease
45379	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	4.37	MPC List	Septembe 000	4.28	8.32	2.17	0.49	930	FALSE		TRUE	Several specific codes ide	October 2018	Complete		TRUE	Decrease
45380	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	3.66	MPC List	October 2000	3.56	9.25	1.87	0.42	1054879	FALSE		TRUE	Several specific codes ide	October 2018	Complete		TRUE	Decrease
45381	Colonoscopy, f	Colonoscopy	January 2018	31		AGA, ASGE	3.67	CMS Faste	October 2000	3.56	9.36	1.87	0.42	82892	TRUE	Jun 2010	Yes	TRUE	Several specific codes ide	October 2018	Complete		TRUE	Decrease
45382	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	4.76	MPC List	Septembe 000	4.66	16.07	2.36	0.51	24121	FALSE		TRUE	Several specific codes ide	October 2018	Complete		TRUE	Decrease
45383	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	Deleted fr	MPC List	September 2011						FALSE		TRUE	Several specific codes ide	October 2018	Complete		TRUE	Deleted from CPT
45384	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	4.17	MPC List	Septembe 000	4.07	10.23	2.01	0.56	77739	FALSE		TRUE	Several specific codes ide	October 2018	Complete		TRUE	Decrease
45385	Colonoscopy, f	Colonoscopy	April 2019	13		AGA, ASGE	4.57	MPC List /	October 2000	4.57	8.62	2.31	0.51	971282	FALSE		TRUE	Several specific codes ide	October 2018	Complete		TRUE	Maintain
45386	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	3.87	MPC List	Septembe 000	3.77	14.77	1.94	0.45	2321	FALSE		TRUE	Several specific codes ide	October 2018	Complete		TRUE	Decrease
45387	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	Deleted fr	MPC List	September 2011						FALSE		TRUE	Several specific codes ide	October 2018	Complete		TRUE	Deleted from CPT
45388	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	4.98	MPC List	January 20000	4.88	79.44	2.41	0.59	26744	FALSE		FALSE		October 2018	Complete		TRUE	Decrease
45389	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	5.50	MPC List	January 20000	5.24	NA	2.60	0.59	420	FALSE		FALSE		October 2018	Complete		TRUE	Decrease
45390	Colonoscopy, f	Colonoscopy	January 2014	10		AGA, ASGE	6.35	MPC List	January 20000	6.04	NA	2.98	0.64	23129	FALSE		FALSE		October 2018	Complete		TRUE	Decrease

45391	Colonoscopy, f	Colonoscopy	January 2014	10			AGA, ASGE	4.95	MPC List	Septembe	000	4.64	NA	2.36	0.48	932	FALSE	TRUE	Several specific codes ide	October 2(	18	Complete	TRUE	Decrease
45392	Colonoscopy, f	Colonoscopy	January 2014	10			AGA, ASGE	5.60	MPC List	Septembe	000	5.5	NA	2.74	0.63	86	FALSE	TRUE	Several specific codes ide	October 2(	18	Complete	TRUE	Decrease
45393	Colonoscopy, f	Colonoscopy	January 2014	10			AGA, ASGE	4.78	MPC List	January 2(	000	4.68	NA	2.10	0.59	2112	FALSE	FALSE		October 2(	18	Complete	TRUE	Decrease
45398	Colonoscopy, f	Colonoscopy	January 2014	10			AGA, ASGE	4.30	MPC List	January 2(	000	4.2	20.44	2.06	0.59	3509	FALSE	FALSE		October 2(	18	Complete	TRUE	Decrease
46020	Placement of s	Placement/Removal	October 2020	16			ACS, ASCR	3.50	010-Day G	October 2(	010	3	4.92	3.50	0.53	1325	FALSE	FALSE					TRUE	Increase
46030	Removal of an	Placement/ Removal	October 2020	16			ACS, ASCR	2.00	010-Day G	April 2020	010	1.26	3.09	1.17	0.21	339	FALSE	FALSE					TRUE	Increase
46200	Fissurectomy,	Fissurectomy	September 200	16			ACS	Reduce 99	Site of Ser	Septembe	090	3.59	10.05	5.72	0.62	992	FALSE	FALSE					TRUE	PE Only
46500	Injection of scl	Hemorrhoid Injectio	January 2018	24			ACS, ASCR	2.00	010-Day G	January 2(	010	1.74	7.52	3.53	0.26	12575	FALSE	FALSE					TRUE	Increase
47011	Hepatotomy; f	Drainage of Abscess	January 2013	04				Deleted fr	Codes Rep	January 2012							FALSE	FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Deleted from CPT
47135	Liver allotrans	Liver Allotransplanta	September 201	14			ACS, ASTS	91.78	090-Day G	January 2(	090	90	NA	46.85	21.53	1590	FALSE	FALSE					TRUE	Increase
47136	Liver allotrans	RAW	April 2014	52			ACS, ASTS	Deleted fr	090-Day G	April 2014							FALSE	TRUE	Identified as part of 4713	October 2(	16	Complete	TRUE	Deleted from CPT
47382	Ablation, 1 or r	Interventional Radio	October 2008	13			ACR, SIR	New PE In	CMS Requ	NA	010	14.97	108.30	5.04	1.34	3121	FALSE	FALSE					TRUE	PE Only
47490	Cholecystostor	Cholecystostomy	October 2009	04			ACR	4.76	CMS Faste	October 2(	010	4.76	NA	4.55	0.42	12075	FALSE	TRUE	This service was referred	June 2009	17	CPT Editoria	TRUE	Decrease
47500	Injection proce	Percutaneous Biliary	October 2015	06	RUC	ACR, SIR	Deleted fr	Codes Rep	October 2012								FALSE	TRUE	The Joint Workgroup recc	February 2	16	Complete	TRUE	Deleted from CPT
47505	Injection proce	Percutaneous Biliary	October 2015	06	RUC	ACR, SIR	Deleted fr	Codes Rep	October 2012								FALSE	TRUE	The Joint Workgroup recc	February 2	16	Complete	TRUE	Deleted from CPT
47510	Introduction o	Percutaneous Biliary	October 2015	06	RUC	ACR, SIR	Deleted fr	Codes Rep	October 2012								FALSE	TRUE	The Joint Workgroup recc	February 2	16	Complete	TRUE	Deleted from CPT
47511	Introduction o	Percutaneous Biliary	October 2015	06	RUC	ACR, SIR	Deleted fr	Codes Rep	October 2012								FALSE	TRUE	The Joint Workgroup recc	February 2	16	Complete	TRUE	Deleted from CPT
47525	Change of per	Percutaneous Biliary	October 2015	06	RUC	ACR, SIR	Deleted fr	High IWPU	February 2008								FALSE	FALSE		February 2	16		TRUE	Deleted from CPT
47530	Revision and/c	Percutaneous Biliary	October 2015	06	RUC	ACR, SIR	Deleted fr	Codes Rep	February 2015								FALSE	FALSE		February 2	16		TRUE	Deleted from CPT
47531	Injection proce	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	1.30	Codes Rep	February 2000			1.3	11.26	0.62	0.13	8621	FALSE	FALSE		February 2	16		TRUE	Increase
47532	Injection proce	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	4.50	Codes Rep	February 2000			4.25	21.37	1.49	0.42	549	FALSE	FALSE		February 2	16		TRUE	Increase
47533	Placement of t	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	5.63	Codes Rep	February 2000			5.38	31.52	1.79	0.48	1518	FALSE	FALSE		February 2	16		TRUE	Increase
47534	Placement of t	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	7.85	Codes Rep	February 2000			7.6	33.18	2.42	0.65	4467	FALSE	FALSE		February 2	16		TRUE	Increase
47535	Conversion of	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	4.20	Codes Rep	February 2000			3.95	24.60	1.35	0.34	438	FALSE	FALSE		February 2	16		TRUE	Increase
47536	Exchange of bi	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	2.86	Codes Rep	February 2000			2.61	17.79	0.96	0.23	14577	FALSE	FALSE		February 2	16		TRUE	Increase
47537	Removal of bil	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	1.85	Codes Rep	February 2000			1.84	12.71	0.77	0.16	1737	FALSE	FALSE		February 2	16		TRUE	Increase
47538	Placement of s	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	5.00	Codes Rep	February 2000			4.75	120.85	1.62	0.43	1025	FALSE	FALSE		February 2	16		TRUE	Increase
47539	Placement of s	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	9.00	Codes Rep	February 2000			8.75	128.69	2.55	0.82	135	FALSE	FALSE		February 2	16		TRUE	Increase
47540	Placement of s	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	9.28	Codes Rep	February 2000			9.03	131.53	2.84	0.80	223	FALSE	FALSE		February 2	16		TRUE	Increase
47541	Placement of a	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	7.00	Codes Rep	February 2000			6.75	29.20	2.22	0.64	170	FALSE	FALSE		February 2	16		TRUE	Increase
47542	Balloon dilatio	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	2.85	Codes Rep	February 2ZZZ			2.85	12.52	0.82	0.25	1346	FALSE	FALSE		February 2	16		TRUE	Increase
47543	Endoluminal b	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	3.00	Codes Rep	February 2ZZZ			3	9.70	0.89	0.26	692	FALSE	FALSE		February 2	16		TRUE	Increase
47544	Removal of cal	Percutaneous Biliary	October 2015	04	RUC	ACR, SIR	3.28	Codes Rep	February 2ZZZ			3.28	24.66	0.93	0.30	322	FALSE	TRUE	The committee noted tha	February 2	16	Complete	TRUE	Increase
47560	Laparoscopy, s	RAW	October 2013	18				Deleted fr	CMS Requ	July 2013							FALSE	FALSE					TRUE	Maintain
47562	Laparoscopy, s	RAW review	September 201	21			ACS	Maintain v	CMS High	Septembe	090	10.47	NA	6.54	2.53	100881	FALSE	FALSE					TRUE	Maintain
47563	Laparoscopy, s	RAW review	October 2013	18				No further	CMS High	Septembe	090	11.47	NA	7.04	2.75	38983	FALSE	FALSE					TRUE	Maintain
47600	Cholecystector	Cholecystectomy	April 2012	36			ACS, SAGE	20.00	CMS Requ	Septembe	090	17.48	NA	10.02	4.14	8195	FALSE	FALSE					TRUE	Increase
47605	Cholecystector	Cholecystectomy	April 2012	36			ACS, SAGE	21.00	CMS Requ	Septembe	090	18.48	NA	10.45	4.42	1408	FALSE	FALSE					TRUE	Increase
48102	Biopsy of panc	Percutaneous Needl	September 200	16			SIR	Reduce 99	Site of Ser	Septembe	010	4.7	10.86	1.75	0.42	960	FALSE	FALSE					TRUE	PE Only
48511	External drain	Drainage of Abscess	January 2013	04				Deleted fr	Codes Rep	January 2012							FALSE	FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Deleted from CPT
49021	Drainage of pe	Drainage of Abscess	January 2013	04			ACR, SIR	Deleted fr	Codes Rep	January 2012							FALSE	FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Deleted from CPT
49041	Drainage of su	Drainage of Abscess	January 2013	04			ACR, SIR	Deleted fr	Codes Rep	January 2012							FALSE	FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Deleted from CPT
49061	Drainage of re	Drainage of Abscess	January 2013	04			ACR, SIR	Deleted fr	Codes Rep	January 2012							FALSE	FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Deleted from CPT
49080	Peritoneocent	Peritoneocentesis	October 2010	5			ACR, AGA,	Deleted fr	Harvard Vi	October 2009							FALSE	TRUE	The specialty reported to	June 2010	09	Complete	TRUE	Deleted from CPT
49081	Peritoneocent	Peritoneocentesis	October 2010	5			ACR, AGA,	Deleted fr	Harvard Vi	February 2010							FALSE	FALSE		June 2010	09		TRUE	Deleted from CPT
49082	Abdominal par	Abdominal Paracent	October 2010	05			ACR, ACS,	1.35	Harvard Vi	February 2000		1.24	5.06	0.72	0.17	11210	FALSE	FALSE		June 2010	09		TRUE	Decrease
49083	Abdominal par	Abdominal Paracent	October 2010	05			ACR, ACS,	2.00	Harvard Vi	February 2000		2	6.90	0.91	0.17	265269	FALSE	FALSE		June 2010	09		TRUE	Decrease
49084	Peritoneal lava	Abdominal Paracent	October 2010	05			ACR, ACS,	2.50	Harvard Vi	February 2000		2	NA	0.75	0.42	1879	FALSE	FALSE		June 2010	09		TRUE	Increase
49405	Image-guided	Drainage of Abscess	January 2013	04			ACR, SIR	4.25	Codes Rep	January 2(	000	4	22.98	1.32	0.34	5880	FALSE	FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Decrease
49406	Image-guided	Drainage of Abscess	January 2013	04			ACR, SIR	4.25	Codes Rep	January 2(	000	4	22.99	1.32	0.34	33397	FALSE	FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Decrease
49407	Image-guided	Drainage of Abscess	January 2013	04			ACR, SIR	4.50	Codes Rep	January 2(	000	4.25	18.03	1.36	0.42	243	FALSE	FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Decrease
49418	Insertion of tu	Intraperitoneal Cath	April 2010	11			ACS, ACR,	4.21	Site of Ser	February 2000		3.96	29.31	1.50	0.39	6497	FALSE	FALSE		February 2	30		TRUE	Decrease
49420	Deleted from (	Insertion of Intraper	October 2009	40			ACS	Deleted fr	Site of Ser	April 2008							FALSE	TRUE	At the April 2008 RUC me	February 2	30	Deleted	TRUE	Deleted from CPT
49421	Insertion of tu	Intraperitoneal Cath	April 2010	11			ACS, ACR,	4.21	Site of Ser	Septembe	000	4.21	NA	1.53	0.96	1848	FALSE	TRUE	At the April 2008 RUC me	February 2	30	Revised	TRUE	Decrease
49422	Removal of tur	Removal of Intraper	April 2017	14			ACS, SVS	4.00	Site of Ser	October 2(	000	4	NA	1.62	0.91	12368	FALSE	FALSE					TRUE	Decrease
49505	Repair initial ir	RAW review	January 2012	30			ACS	Reaffirme	CMS High	Septembe	090	7.96	NA	5.60	1.92	50710	FALSE	FALSE					TRUE	Maintain
49507	Repair initial ir	Hernia Repair	February 2011	29			ACS	10.05	Site of Ser	Septembe	090	9.09	NA	6.12	2.16	10329	FALSE	FALSE					TRUE	Maintain
49521	Repair recurre	Hernia Repair	February 2011	29			ACS	12.44	Site of Ser	Septembe	090	11.48	NA	7.00	2.74	1809	FALSE	FALSE					TRUE	Maintain
49560	Repair initial ir	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		11.92	NA	7.11	2.79	22089	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49561	Repair initial ir	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		15.38	NA	8.45	3.64	12726	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49565	Repair recurre	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	October 2(	090	12.37	NA	7.46	2.90	5211	FALSE	TRUE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49566	Repair recurre	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		15.53	NA	8.51	3.68	3748	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49568	Implantation o	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2ZZZ		4.88	NA	1.82	1.15	27767	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49570	Repair epigast	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		6.05	NA	4.93	1.46	616	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49572	Repair epigast	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		7.87	NA	5.60	1.90	451	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49580	Repair umbilic	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		4.47	NA	4.42	1.10		FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49582	Repair umbilic	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		7.13	NA	5.50	1.74	0	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49585	Repair umbilic	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		6.59	NA	5.10	1.56	18847	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49587	Repair umbilic	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	Septembe	090	7.08	NA	5.37	1.69	7947	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49590	Repair spigelia	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		8.9	NA	5.98	2.14	714	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49652	Laparoscopy, s	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	June 2010	090	11.92	NA	7.26	2.85	9327	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49653	Laparoscopy, s	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	June 2010	090	14.94	NA	9.02	3.60	5848	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49654	Laparoscopy, s	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	June 2010	090	13.76	NA	7.95	3.28	7253	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49655	Laparoscopy, s	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	June 2010	090	16.84	NA	9.73	4.03	4804	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49656	Laparoscopy, s	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		15.08	NA	8.43	3.61	1697	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
49657	Laparoscopy, s	Anterior Abdominal	April 2021	09			ACS, ASCR	Deleted fr	Site of Ser	February 2090		22.11	NA	11.62	5.29	1503	FALSE	FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Deleted from CPT
50021	Drainage of pe	Drainage of Abscess	January 2013	04				Deleted fr	Codes Rep	January 2012							FALSE	FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Deleted from CPT
50080	Percutaneous	Percutaneous Nephr	January 2020	25	January 2(	RUC	AUA, SIR	Refer to Cl	Site of Ser	October 2(	090	15.74	NA	7.75	1.82	2659	FALSE	TRUE	In January 2020, the spec	Septembe	22	complete	FALSE	
50081	Percutaneous	Percutaneous Nephr	January 2020	25	January 2(	RUC	AUA, SIR	Refer to Cl	Site of Ser	October 2(	090	23.5	NA	10.97	2.71	5937	FALSE	TRUE	In January 2020, the spec	Septembe	22	complete	FALSE	
50200	Renal biopsy; p	Interventional Radio	October 2008	13			ACR, SIR	New PE In	CMS Requ	NA	000	2.38	13.71	1.10	0.21	38395	FALSE	FALSE					TRUE	PE Only

50360	Renal allotrans	Renal Allotransplant	April 2013	21			ACR, SIR	40.90	Harvard-V	July 2012	090	39.88	NA	22.26	9.28	12479	FALSE			FALSE						TRUE	Maintain
50387	Removal and r	Genitourinary Cathe	January 2015	09			ACR, SIR	2.00	Codes Rep	October 2(	000	1.75	15.40	0.51	0.15	7721	FALSE			FALSE		October 2(	18	Complete		TRUE	Maintain
50392	Introduction o	Genitourinary Cathe	January 2015	09			ACR, SIR	Deleted fr	Codes Rep	October 2012							FALSE			TRUE	The Joint Workgroup recc	October 2(	18	Complete		TRUE	Deleted from CPT
50393	Introduction o	Genitourinary Cathe	January 2015	09			ACR, SIR	Deleted fr	Codes Rep	October 2012							FALSE			TRUE	The Joint Workgroup recc	October 2(	18	Complete		TRUE	Deleted from CPT
50394	Injection proce	Genitourinary Cathe	January 2015	09			ACR, SIR	Deleted fr	Codes Rep	October 2012							FALSE			TRUE	The Joint Workgroup recc	October 2(	18	Complete		TRUE	Deleted from CPT
50395	Introduction o	Dilation of Urinary T	January 2018	12			ACR, SIR	Deleted fr	Codes Rep	October 2014							FALSE			TRUE	In January 2015, the spec	Septembe	19	complete		TRUE	Deleted from CPT
50398	Change of nep	Genitourinary Cathe	January 2015	09			ACR, SIR	Deleted fr	Codes Rep	October 2012							FALSE			TRUE	The Joint Workgroup recc	October 2(	18	Complete		TRUE	Deleted from CPT
50430	Injection proce	Genitourinary Cathe	January 2015	09			ACR, SIR	3.15	Codes Rep	October 2(	000	2.9	15.41	1.28	0.27	1007	FALSE			FALSE		October 2(	18	Complete		TRUE	Increase
50431	Injection proce	Genitourinary Cathe	January 2015	09			ACR, SIR	1.42	Codes Rep	October 2(	000	1.1	7.92	0.69	0.10	8818	FALSE			FALSE		October 2(	18	Complete		TRUE	Increase
50432	Placement of r	Dilation of Urinary T	January 2018	12			ACR, SIR	4.00	Codes Rep	October 2(	000	4	23.39	1.57	0.34	28285	FALSE			FALSE		October 2(	18	Complete		TRUE	Maintain
50433	Placement of r	Dilation of Urinary T	January 2018	12				5.05	Codes Rep	Septembe	000	5.05	29.70	1.85	0.45	5572	FALSE			FALSE						TRUE	Maintain
50434	Convert nephr	Genitourinary Cathe	January 2015	09			ACR, SIR	4.20	Codes Rep	October 2(	000	3.75	24.12	1.45	0.33	2477	FALSE			FALSE		October 2(	18	Complete		TRUE	Increase
50435	Exchange nepl	Genitourinary Cathe	January 2015	09			ACR, SIR	2.00	Codes Rep	October 2(	000	1.82	16.19	0.89	0.15	46684	FALSE			FALSE		October 2(	18	Complete		TRUE	Increase
50436	Dilation of exis	Dilation of Urinary T	January 2018	12				3.37	Codes Rep	Septembe	000	2.78	NA	1.31	0.27	607	FALSE			FALSE						TRUE	Decrease
50437	Dilation of exis	Dilation of Urinary T	January 2018	12				5.44	Codes Rep	Septembe	000	4.85	NA	1.93	0.45	1196	FALSE			FALSE						TRUE	Decrease
50542	Laparoscopy, s	Laproscopic Proced	October 2008	26			AUA	Remove fr	CMS Faste	October 2(	090	21.36	NA	10.11	2.54	197	FALSE			FALSE						TRUE	Remove from Screen
50548	Laparoscopy, s	Laproscopic Proced	October 2008	26			AUA	Remove fr	CMS Faste	October 2(	090	25.36	NA	10.78	3.01	2422	FALSE			FALSE						TRUE	Remove from Screen
50590	Lithotripsy, ext	Lithotripsy	April 2012	42			AUA	9.77	CMS High	Septembe	090	9.77	11.03	5.72	1.14	54658	FALSE			FALSE						TRUE	Maintain
50605	Ureterotomy f	Ureterotomy	October 2015	21	RAW		AUA, SIR	Review ac	CMS Faste	October 2(	090	16.79	NA	9.05	3.52	3602	TRUE	Dec 2009	Yes	FALSE						TRUE	Maintain
50606	Endoluminal b	Genitourinary Cathe	April 2015	08			ACR, SIR	3.16	Codes Rep	October 2(	ZZZ	3.16	13.99	0.91	0.27	104	FALSE			TRUE		October 2(	18	Complete		TRUE	Increase
50693	Placement of ı	Genitourinary Cathe	January 2015	09			ACR, SIR	4.60	Codes Rep	October 2(	000	3.96	27.17	1.58	0.34	4504	FALSE			FALSE		October 2(	18	Complete		TRUE	Increase
50694	Placement of ı	Genitourinary Cathe	January 2015	09			ACR, SIR	6.00	Codes Rep	October 2(	000	5.25	29.30	1.99	0.45	981	FALSE			FALSE		October 2(	18	Complete		TRUE	Increase
50695	Placement of ı	Genitourinary Cathe	January 2015	09			ACR, SIR	7.55	Codes Rep	October 2(	000	6.8	34.84	2.52	0.59	1321	FALSE			FALSE		October 2(	18	Complete		TRUE	Increase
50705	Ureteral embo	Genitourinary Cathe	April 2015	08			ACR, SIR	4.03	Codes Rep	October 2(	ZZZ	4.03	53.59	0.65	0.41	65	FALSE			TRUE		October 2(	18	Complete		TRUE	Increase
50706	Balloon dilatio	Genitourinary Cathe	April 2015	08			ACR, SIR	3.80	Codes Rep	October 2(	ZZZ	3.8	23.29	1.11	0.34	1459	FALSE			TRUE		October 2(	18	Complete		TRUE	Increase
51040	Cystostomy, c	Cystostomy	September 200	16			AUA	Reduce 99	Site of Ser	Septembe	090	4.49	NA	3.48	0.52	5029	FALSE			FALSE						TRUE	PE Only
51102	Aspiration of b	Urological Procedur	April 2008	45			AUA	2.70	Site of Ser	Septembe	000	2.7	4.21	1.23	0.28	14265	FALSE			FALSE						TRUE	Decrease
51700	Bladder irrigat	Bladder Catheter	January 2016	32			AUA	0.60	CMS High	July 2015	000	0.6	1.63	0.21	0.09	194801	FALSE			FALSE						TRUE	Decrease
51701	Insertion of no	Bladder Catheter	January 2016	32			AUA	0.50	CMS High	July 2015	000	0.5	0.78	0.18	0.06	168108	FALSE			FALSE						TRUE	Maintain
51702	Insertion of tei	Bladder Catheter	January 2016	32			AUA	0.50	CMS High	July 2015	000	0.5	1.32	0.18	0.05	234004	FALSE			FALSE						TRUE	Maintain
51703	Insertion of tei	Bladder Catheter	January 2016	32			AUA	1.47	CMS High	July 2015	000	1.47	2.73	0.58	0.17	54647	FALSE			FALSE						TRUE	Maintain
51720	Bladder instilla	Treatment of Bladde	January 2016	33			AUA	0.87	CMS High	July 2015	000	0.87	1.64	0.30	0.10	160447	FALSE			FALSE						TRUE	Decrease
51726	Complex cysto	Urodynamic Studies	April 2009	16			AUA, ACO	1.71	Codes Rep	February 2	000	1.71	7.14	NA	0.17	4438	FALSE			TRUE	Referred to the CPT Edito	February 2	24	Complete		TRUE	Maintain
51727	Complex cysto	Urodynamic Studies	April 2009	16			AUA, ACO	2.11	Codes Rep	February 2	000	2.11	8.52	NA	0.22	1982	FALSE			FALSE						TRUE	Decrease
51728	Complex cysto	Urodynamic Studies	April 2009	16			AUA, ACO	2.11	Codes Rep	February 2	000	2.11	8.65	NA	0.19	85150	FALSE			FALSE						TRUE	Decrease
51729	Complex cysto	Urodynamic Studies	April 2009	16			AUA, ACO	2.51	Codes Rep	February 2	000	2.51	8.84	NA	0.27	61880	FALSE			FALSE						TRUE	Decrease
51736	Simple uroflow	Uroflowmetry	October 2010	11			AUA	0.17	Harvard V	February 2	XXX	0.17	0.20	NA	0.02	10797	FALSE			FALSE						TRUE	Decrease
51741	Complex urofl	Uroflowmetry	October 2010	11			AUA	0.17	Harvard V	October 2(	XXX	0.17	0.21	NA	0.03	423494	FALSE			FALSE						TRUE	Decrease
51772	Deleted from (	Urodynamic Studies	April 2009	16			AUA	Deleted fr	Codes Rep	February 2008							FALSE			TRUE	Referred to the CPT Edito	February 2	24	Code Delete		TRUE	Deleted from CPT
51784	Electromyogra	Electromyography S	January 2019	37			AUA	0.75. Main	Codes Rep	October 2(	XXX	0.75	1.11	NA	0.07	142000	TRUE	Feb 2014	Yes	TRUE	The Joint Workgroup refe	February 2	34	Complete		TRUE	Decrease
51792	Stimulus evoke	Urinary Reflex Studi	January 2019	37			AUA	CPT edits a	Codes Rep	October 2(	000	1.1	6.72	NA	0.11	7152	TRUE	Feb 2014	Yes	TRUE	The Joint Workgroup refe	February 2	34	Complete		TRUE	Maintain
51795	Deleted from (	Urology Studies	February 2008	S				Deleted fr	Codes Rep	February 2008							FALSE			TRUE	Referred to the CPT Edito	February 2	24	Code Delete		TRUE	Deleted from CPT
51797	Voiding pressu	Urology Studies	February 2008	S				0.80	Codes Rep	February 2	ZZZ	0.8	4.66	NA	0.06	116064	FALSE			TRUE	Referred to the CPT Edito	February 2	24	Code Revise		TRUE	Maintain
51798	Measurement	Voiding Pressure St	April 2016	25			AUA	PE Only	CMS High	July 2015	XXX	0	0.29	NA	0.01	2169510	FALSE			FALSE						TRUE	PE Only
52000	Cystourethrosc	Cystourethroscopy	January 2016	35			AUA, ACO	1.75	MPC List /	October 2(	000	1.53	5.21	0.63	0.17	897375	FALSE			FALSE						TRUE	Decrease
52214	Cystourethrosc	Cystourethroscopy	October 2017	19			AUA	3.50	High Volur	June 2008	000	3.5	19.06	1.20	0.42	16853	TRUE	Aug 2009	Yes	FALSE						TRUE	Decrease
52224	Cystourethrosc	Cystourethroscopy	October 2017	19			AUA	4.05	High Volur	February 2	000	4.05	19.41	1.39	0.46	36291	TRUE	Aug 2009	Yes	FALSE						TRUE	Increase
52234	Cystourethrosc	Cystourethroscopy a	January 2021	29			AUA	4.62	Harvard V	Septembe	000	4.62	NA	1.96	0.53	28317	TRUE	May 2016	Yes	FALSE						TRUE	Maintain
52235	Cystourethrosc	Cystourethroscopy a	October 2017	19			AUA	5.44	Harvard V	April 2011	000	5.44	NA	2.27	0.64	33411	TRUE	May 2016	Yes	FALSE						TRUE	Maintain
52240	Cystourethrosc	Cystourethroscopy a	January 2021	29			AUA	8.75	Harvard V	Septembe	000	7.5	NA	2.98	0.86	21956	TRUE	May 2016	Yes	FALSE						TRUE	Decrease
52281	Cystourethrosc	Cystourethroscopy	April 2010	38			AUA	2.80	Harvard V	October 2(	000	2.75	6.79	1.33	0.32	62618	FALSE			FALSE						TRUE	Maintain
52287	Cystourethroscopy, with injection(s		January 2020	37				Remove fr	High Volur	October 2(	000	3.2	7.82	1.32	0.39	51037	FALSE			FALSE						TRUE	Remove from Screen
52332	Cystourethrosc	Cystourethroscopy	April 2013	13			AUA	2.82	Harvard V	October 2(	000	2.82	9.94	1.35	0.33	151015	FALSE			TRUE	The Joint Workgroup recc	February 2	15	Complete		TRUE	Maintain
52334	Cystourethrosc	Dilation of Urinary T	January 2018	12				3.37	Codes Rep	Septembe	000	3.37	NA	1.54	0.39	289	FALSE			FALSE						TRUE	Decrease
52341	Cystourethrosc	Urological Procedur	October 2010	65			AUA	5.35	Site of Ser	April 2008	000	5.35	NA	2.24	0.63	2487	FALSE			FALSE						TRUE	Decrease
52342	Cystourethrosc	Urological Procedur	October 2010	65			AUA	5.85	Site of Ser	April 2008	000	5.85	NA	2.41	0.68	191	FALSE			FALSE						TRUE	Decrease
52343	Cystourethrosc	Urological Procedur	October 2010	65			AUA	6.55	Site of Ser	April 2008	000	6.55	NA	2.65	0.74	21	FALSE			FALSE						TRUE	Decrease
52344	Cystourethrosc	Urological Procedur	October 2010	65			AUA	7.05	Site of Ser	Septembe	000	7.05	NA	2.82	0.80	3393	FALSE			FALSE						TRUE	Decrease
52345	Cystourethrosc	Urological Procedur	October 2010	65			AUA	7.55	Site of Ser	April 2008	000	7.55	NA	3.00	0.86	480	FALSE			FALSE						TRUE	Decrease
52346	Cystourethrosc	Urological Procedur	October 2010	65			AUA	8.58	Site of Ser	April 2008	000	8.58	NA	3.35	0.99	212	FALSE			FALSE						TRUE	Decrease
52351	Cystourethrosc	Cystourethroscopy a	September 201	23			AUA	5.75	Harvard V	Septembe	000	5.75	NA	2.34	0.66	22929	FALSE			FALSE						TRUE	Decrease
52352	Cystourethrosc	Cystourethroscopy a	September 201	23			AUA	6.75	Harvard V	Septembe	000	6.75	NA	2.72	0.77	24811	FALSE			FALSE						TRUE	Decrease
52353	Cystourethrosc	Cystourethroscopy	April 2013	13			AUA	7.50	Harvard V	April 2011	000	7.5	NA	2.98	0.86	11180	FALSE			TRUE	The Joint Workgroup recc	February 2	15	Complete		TRUE	Decrease
52354	Cystourethrosc	Cystourethroscopy a	September 201	23			AUA	8.58	Harvard V	Septembe	000	8	NA	3.15	0.93	9144	FALSE			FALSE						TRUE	Increase
52355	Cystourethrosc	Cystourethroscopy a	September 201	23			AUA	10.00	Harvard V	Septembe	000	9	NA	3.49	1.03	1007	FALSE			FALSE						TRUE	Increase
52356	Cystourethrosc	Cystourethroscopy	April 2013	13			AUA	8.00	Codes Rep	January 2(	000	8	NA	3.11	0.93	78507	FALSE			FALSE						TRUE	Decrease
52400	Cystourethrosc	Urological Procedur	October 2010	65			AUA	8.69	Site of Ser	Septembe	090	8.69	NA	4.19	1.00	115	FALSE			FALSE						TRUE	Decrease
52442	Cystourethrosc	PE Subcommittee	October 2020	24			AUA, AACI	Maintain	PE Units S	April 2020	ZZZ	1.01	28.12	0.35	0.13	101717	FALSE			FALSE						TRUE	Maintain
52500	Transurethral ı	Urological Procedur	October 2010	65			AUA	8.14	Site of Ser	Septembe	090	8.14	NA	5.24	0.94	3173	FALSE			FALSE						TRUE	Decrease
52601	Transurethral ı	Transurethral Electr	April 2016	26			AUA	13.16	Site of Ser	October 2(	090	13.16	NA	6.56	1.51	44942	FALSE			FALSE						TRUE	Decrease
52640	Transurethral ı	Urological Procedur	April 2008	45			AUA	4.79	Site of Ser	Septembe	090	4.79	NA	3.98	0.54	1396	FALSE			FALSE						TRUE	Decrease
52648	Laser vaporiza	Laser Surgery of Pro	April 2008	57			AUA	Remove fr	High Volur	February 2	090	12.15	36.73	6.60	1.42	18059	FALSE			FALSE						TRUE	Remove from Screen
53445	Insertion of inf	Urological Procedur	February 2011	31			AUA	13.00	Site of Ser	Septembe	090	13	NA	7.55	1.50	2071	FALSE			FALSE						TRUE	Decrease
53850	Transurethral ı	Transurethral Destr	April 2012	43			AUA	10.08	CMS High	Septembe	090	5.42	40.18	4.25	0.64	2363	FALSE			FALSE						TRUE	Maintain
54405	Insertion of mu	Urological Procedur	April 2008	45			AUA	14.39	Site of Ser	Septembe	090	14.52	NA	7.40	1.66	5217	FALSE			FALSE						TRUE	Maintain
54410	Removal and r	Urological Procedur	February 2011	31			AUA	15.18	Site of Ser	Septembe	090	15.18	NA	8.22	1.76	1286	FALSE			FALSE						TRUE	Decrease
54520	Orchiectomy, s	Removal of Testical	September 200	16			AUA	Reduce 99	Site of Ser	Septembe	090	5.3	NA	3.61	0.68	2671	FALSE			FALSE						TRUE	PE Only
54530	Orchiectomy, r	Urological Procedur	October 2010	65			AUA	8.46	Site of Ser	Septembe	090	8.46	NA	5.37	1.02	1190	FALSE			FALSE						TRUE	Decrease
55700	Biopsy, prosta	Biopsy of Prostate	January 2016	36			AUA	2.50	CMS High	July 2015	000	2.5	4.57	1.00	0.28	156362	FALSE			FALSE						TRUE	Decrease
55706	Biopsies, prost	RAW	April 2014	52				Maintain	010-Day G	January 2(	010	6.28	NA	3.95	0.70	2297	FALSE			FALSE						TRUE	Maintain

55840	Prostatectomy, retropubic radical, '	April 2014	31		AUA	21.36	CMS Requ	October 2(	090	21.36	NA	10.22	2.48	1610	FALSE		FALSE					TRUE	Decrease
55842	Prostatectomy, retropubic radical, '	April 2014	31		AUA	24.16	CMS Requ	October 2(	090	21.36	NA	10.24	2.52	150	FALSE		FALSE					TRUE	Decrease
55845	Prostatectomy RAW	April 2014	31		AUA	29.07	CMS Requ	July 2013	090	25.18	NA	11.53	2.91	1030	FALSE		FALSE					TRUE	Decrease
55866	Laparoscopy, s Laparoscopic Radica	April 2015	27	RUC	AUA	26.80	New Tech	Septembe	090	26.8	NA	12.05	3.10	20334	FALSE		TRUE	The specialty society reported that it will subm		Complete		TRUE	Decrease
55873	Cryosurgical al Cryoablation of Pros	February 2009	25		AUA	13.45	CMS Requ	Septembe	090	13.6	171.52	7.11	1.57	1648	FALSE		FALSE					TRUE	Decrease
55875	Transperineal RAW	October 2015	21				Review da	RUC requ	April 2015	090	13.46	NA	7.66	1.41	6399	FALSE		FALSE					TRUE	Not Part of RAW
56515	Destruction of Destruction of Lesio	September 200	16		ACOG		Reduce 99	Site of Ser	Septembe	010	3.08	4.41	2.65	0.47	3187	FALSE		FALSE					TRUE	PE Only
56620	Vulvectomy sir Partial Removal of V	February 2008	D		ACOG	7.35	Site of Ser	Septembe	090	7.53	NA	8.20	1.20	3143	FALSE		FALSE					TRUE	Decrease
57150	Irrigation of va Vaginal Treatments	April 2017	15		ACOG	0.50	CMS 000-D	July 2016	000	0.5	1.13	0.19	0.09	24482	FALSE		FALSE					TRUE	Decrease
57155	Insertion of ut RAW	January 2017	30		ACOG, AS	5.40	Site of Ser	Septembe	000	5.15	5.80	2.64	0.43	3111	FALSE		TRUE	ACOG conducted original	October 2(	33	Complete	TRUE	Decrease
57156	Insertion of a RAW	January 2017	30		ACOG, AS	2.69	Site of Ser	Septembe	000	2.69	3.65	1.47	0.20	15369	FALSE		FALSE		October 2(	33		TRUE	Decrease
57160	Fitting and ins Vaginal Treatments	April 2017	15		ACOG	0.89	CMS 000-D	July 2016	000	0.89	1.11	0.34	0.14	85733	FALSE		FALSE					TRUE	Maintain
57240	Anterior colpo Colporrhaphy with C	January 2017	14		ACOG	10.08	Site of Ser	October 2(	090	10.08	NA	6.44	1.46	9026	FALSE		TRUE	In October 2015, CPT cod	Septembe	35	yes	TRUE	Decrease
57250	Posterior colpo Colporrhaphy with C	January 2017	14		ACOG	10.08	Site of Ser	April 2016	090	10.08	NA	6.48	1.52	8757	FALSE		TRUE	In October 2015, CPT cod	Septembe	35	yes	TRUE	Decrease
57260	Combined anti Colporrhaphy with C	January 2017	14		ACOG	13.25	Site of Ser	April 2016	090	13.25	NA	7.67	2.00	9740	FALSE		TRUE	In October 2015, CPT cod	Septembe	35	yes	TRUE	Decrease
57265	Combined anti Colporrhaphy with C	January 2017	14		ACOG	15.00	Site of Ser	April 2016	090	15	NA	8.38	2.32	4370	FALSE		TRUE	In October 2015, CPT cod	Septembe	35	yes	TRUE	Decrease
57282	Colpopexy, vag Colpopexy	January 2020	26			13.48	Site of Ser	October 2(	090	11.63	NA	7.05	1.74	7042	FALSE		FALSE					TRUE	Increase
57283	Colpopexy, vag Colpopexy	January 2020	26			13.51	Site of Ser	October 2(	090	11.66	NA	7.11	1.79	5777	FALSE		FALSE					TRUE	Increase
57287	Removal or re Urological Procedur	February 2008	C		AUA	10.97	Site of Ser	Septembe	090	11.15	NA	8.93	1.56	1737	FALSE		FALSE					TRUE	Decrease
57288	Sling operatior Sling Operation for S	February 2008	O		ACOG, AU	12.00	New Tech	Septembe	090	12.13	NA	7.93	1.73	25452	FALSE		FALSE					TRUE	Decrease
57425	Laparoscopy, s Laparoscopic Colope	January 2020	27			18.02	Site of Ser	October 2(	090	17.03	NA	9.10	2.52	9468	FALSE		FALSE					TRUE	Increase
58100	Endometrial sa Biopsy of Uterus Lin	April 2017	16		ACOG	1.21	CMS 000-D	July 2016	000	1.21	1.60	0.47	0.20	68910	FALSE		FALSE					TRUE	Decrease
58110	Endometrial sa Biopsy of Uterus Lin	April 2017	16		ACOG	0.77	CMS 000-D	April 2017	ZZZ	0.77	0.59	0.30	0.13	672	FALSE		FALSE					TRUE	Maintain
58555	Hysteroscopy, Hysteroscopy	January 2016	37		ACOG	3.07	CMS Requ	NA	000	2.65	7.57	1.38	0.43	1494	FALSE		FALSE					TRUE	Decrease
58558	Hysteroscopy, Hysteroscopy	January 2016	37		ACOG	4.37	CMS Requ	NA	000	4.17	38.05	1.96	0.65	47694	FALSE		FALSE					TRUE	Decrease
58559	Hysteroscopy, Hysteroscopy	January 2016	37		ACOG	5.54	CMS High	July 2015	000	5.2	NA	2.35	0.81	121	FALSE		FALSE					TRUE	Decrease
58560	Hysteroscopy, Hysteroscopy	January 2016	37		ACOG	6.15	CMS High	July 2015	000	5.75	NA	2.55	0.92	44	FALSE		FALSE					TRUE	Decrease
58561	Hysteroscopy, Hysteroscopy	January 2016	37		ACOG	7.00	CMS High	July 2015	000	6.6	NA	2.89	1.03	2396	FALSE		FALSE					TRUE	Decrease
58562	Hysteroscopy, Hysteroscopy	January 2016	37		ACOG	4.17	CMS Requ	NA	000	4	8.07	1.88	0.64	206	FALSE		FALSE					TRUE	Decrease
58563	Hysteroscopy, Hysteroscopy	January 2016	37		ACOG	4.62	CMS Requ	NA	000	4.47	59.54	2.06	0.71	2831	FALSE		FALSE					TRUE	Decrease
58660	Laparoscopy, s Laproscopic Proced	September 200	16		AUA, ACO		Reduce 99	Site of Ser	Septembe	090	11.59	NA	6.43	2.03	761	FALSE		FALSE					TRUE	PE Only
58661	Laparoscopy, s Laproscopic Proced	September 200	16		ACOG		Reduce 99	Site of Ser	Septembe	010	11.35	NA	6.04	1.82	13081	FALSE		FALSE					TRUE	PE Only
58823	Drainage of pe Drainage of Abscess	January 2013	04				Deleted fr	Codes Rep	January 2012						FALSE		FALSE	Deleted nine codes that c	October 2(	06	Complete	TRUE	Deleted from CPT
59400	Routine obstet Obstetrical Care	October 2009	15		ACOG, AAI	32.69	High IWPU	February 2	MMM	36.58	NA	24.40	9.28	2825	FALSE		FALSE					TRUE	Increase
59409	Vaginal deliver Obstetrical Care	October 2009	15		ACOG, AAI	14.37	High IWPU	February 2	MMM	14.37	NA	5.67	3.60	1615	FALSE		FALSE					TRUE	Increase
59410	Vaginal deliver Obstetrical Care	October 2009	15		ACOG, AAI	18.54	High IWPU	February 2	MMM	18.34	NA	8.24	4.59	823	FALSE		FALSE					TRUE	Increase
59412	External ceph Obstetrical Care	October 2009	15		ACOG, AAI	1.71	High IWPU	April 2008	MMM	1.71	NA	0.83	0.47	29	FALSE		FALSE					TRUE	Maintain
59414	Delivery of pla Obstetrical Care	October 2009	15		ACOG, AAI	1.61	High IWPU	April 2008	MMM	1.61	NA	0.62	0.45	56	FALSE		FALSE					TRUE	Maintain
59425	Antepartum ca Obstetrical Care	October 2009	15		ACOG, AAI	6.31	High IWPU	April 2008	MMM	7.8	6.63	3.05	1.96	666	FALSE		FALSE					TRUE	Decrease
59426	Antepartum ca Obstetrical Care	October 2009	15		ACOG, AAI	11.16	High IWPU	April 2008	MMM	14.3	12.14	5.62	3.55	710	FALSE		FALSE					TRUE	Decrease
59430	Postpartum ca Obstetrical Care	October 2009	15		ACOG, AAI	2.47	High IWPU	April 2008	MMM	3.22	3.59	1.26	0.81	1138	FALSE		FALSE					TRUE	Increase
59510	Routine obstet Obstetrical Care	October 2009	15		ACOG, AAI	36.17	High IWPU	February 2	MMM	40.39	NA	26.09	11.12	2365	FALSE		FALSE					TRUE	Increase
59514	Cesarean deliv Obstetrical Care	October 2009	15		ACOG, AAI	16.13	High IWPU	October 2(	MMM	16.13	NA	6.25	4.37	1266	FALSE		FALSE					TRUE	Increase
59515	Cesarean deliv Obstetrical Care	October 2009	15		ACOG, AAI	22.00	High IWPU	April 2008	MMM	22.13	NA	10.19	6.09	760	FALSE		FALSE					TRUE	Increase
59610	Routine obstet Obstetrical Care	October 2009	15		ACOG, AAI	34.40	High IWPU	April 2008	MMM	38.29	NA	24.53	10.63	89	FALSE		FALSE					TRUE	Increase
59612	Vaginal deliver Obstetrical Care	October 2009	15		ACOG, AAI	16.09	High IWPU	April 2008	MMM	16.09	NA	6.14	4.48	65	FALSE		FALSE					TRUE	Increase
59614	Vaginal deliver Obstetrical Care	October 2009	15		ACOG, AAI	20.26	High IWPU	April 2008	MMM	20.06	NA	8.11	5.58	36	FALSE		FALSE					TRUE	Increase
59618	Routine obstet Obstetrical Care	October 2009	15		ACOG, AAI	36.69	High IWPU	April 2008	MMM	40.91	NA	26.17	11.37	22	FALSE		FALSE					TRUE	Increase
59620	Cesarean deliv Obstetrical Care	October 2009	15		ACOG, AAI	16.66	High IWPU	April 2008	MMM	16.66	NA	6.36	4.60	13	FALSE		FALSE					TRUE	Decrease
59622	Cesarean deliv Obstetrical Care	October 2009	15		ACOG, AAI	22.53	High IWPU	April 2008	MMM	22.66	NA	10.81	6.31	6	FALSE		FALSE					TRUE	Increase
60220	Total thyroid l Total Thyroid Lobect	April 2008	46		ACS, AAO-	12.29	Site of Ser	Septembe	090	11.19	NA	7.47	2.05	7841	FALSE		FALSE					TRUE	Maintain
60225	Total thyroid l Total Thyroid Lobect	April 2008	46		ACS, AAO-	14.67	Site of Ser	Septembe	090	14.79	NA	9.89	2.66	308	FALSE		FALSE					TRUE	Maintain
60520	Thymectomy, RAW Review	January 2013	34				No reliable	CMS Requ	November	090	17.16	NA	9.81	3.84	437	FALSE		FALSE					TRUE	Remove from Screen
60521	Thymectomy, RAW Review	January 2013	34				No reliable	CMS Requ	November	090	19.18	NA	9.29	4.38	254	FALSE		FALSE					TRUE	Remove from Screen
60522	Thymectomy, RAW Review	January 2013	34				No reliable	CMS Requ	November	090	23.48	NA	11.24	5.33	120	FALSE		FALSE					TRUE	Remove from Screen
61055	Cisternal or lat Myelography	April 2014	17				Editorial cl	Codes Rep	January 2(	000	2.1	NA	1.06	0.34	293	FALSE		TRUE	This code change applica	October 2(	21	Complete	TRUE	Remove from screen
61781	Stereotactic cc Stereotactic Comput	February 2010	13		NASS, AAN	3.75	CMS Faste	October 2(	ZZZ	3.75	NA	1.79	1.39	15851	FALSE		FALSE		October 2(	34		TRUE	Decrease
61782	Stereotactic cc Stereotactic Comput	February 2010	13		NASS, AAN	3.18	CMS Faste	October 2(	ZZZ	3.18	NA	1.41	0.45	18750	FALSE		FALSE		October 2(	34		TRUE	Decrease
61783	Stereotactic cc Stereotactic Comput	February 2010	13		NASS, AAN	3.75	CMS Faste	October 2(	ZZZ	3.75	NA	1.82	1.25	18207	FALSE		FALSE		October 2(	34		TRUE	Decrease
61793	Deleted from (Stereotactic Radiosu	October 2008	26		AANS		Deleted fr	CMS Faste	September 2007						FALSE		FALSE		February 2008			TRUE	Deleted from CPT
61795	Deleted from (Stereotactic Radiosu	February 2009	38		NASS, AAC		Deleted fr	CMS Faste	October 2008						FALSE		TRUE	The specialty commentec	October 2(	34	Code Delete	TRUE	Deleted from CPT
61796	Stereotactic ra Stereotactic Radiosu	February 2009	38			15.50	CMS Requ	NA	090	13.93	NA	10.94	5.14	6704	FALSE		FALSE					TRUE	Decrease
61797	Stereotactic ra Stereotactic Radiosu	February 2009	38			3.48	CMS Requ	NA	ZZZ	3.48	NA	1.68	1.29	8122	FALSE		FALSE					TRUE	Decrease
61798	Stereotactic ra Stereotactic Radiosu	February 2009	38			19.75	CMS Requ	NA	090	19.85	NA	13.63	7.18	3528	FALSE		FALSE					TRUE	Decrease
61799	Stereotactic ra Stereotactic Radiosu	February 2009	38			4.81	CMS Requ	NA	ZZZ	4.81	NA	2.30	1.76	570	FALSE		FALSE					TRUE	Decrease
61800	Application of Stereotactic Radiosu	April 2008	16			2.25	CMS Faste	February 2	ZZZ	2.25	NA	1.41	0.82	5499	FALSE		FALSE					TRUE	Decrease
61885	Insertion or re Vagal Nerve Stimula	February 2010	14		AANS/CNS	6.44	Site of Ser	Septembe	090	6.05	NA	7.30	2.14	5787	FALSE		TRUE	In Feb 2009, the specialty	October 2(	35	Complete	TRUE	Decrease
62263	Percutaneous Epidual Lysis	October 2010	66		AAPM, AA	6.54	Site of Ser	Septembe	010	5	13.40	3.59	0.45	302	FALSE		FALSE					TRUE	Maintain
62270	Spinal punctur Lumbar Puncture	January 2019	09		ACR, ASNR	1.44	Different F	October 2(	000	1.22	2.50	0.41	0.16	79126	FALSE		TRUE	In January 2018, the RUC	Septembe	24	Complete	TRUE	Increase
62272	Spinal punctur Lumbar Puncture	January 2019	09			1.80	Different F	Septembe	000	1.58	3.31	0.65	0.34	6301	FALSE		FALSE		Septembe	24	Complete	TRUE	Increase
62281	Injection/infus Injection of Neurolyt	September 200	16		ASA		Remove 9	Site of Ser	Septembe	010	2.66	4.32	1.76	0.25	390	TRUE	Q&A May	Yes	FALSE				TRUE	PE Only
62284	Injection proc Myelography	April 2014	17		ACR, ASNR	1.54	Codes Rep	October 2(	000	1.54	4.18	0.77	0.17	16213	FALSE		TRUE	Joint Workgroup request:	October 2(	21	Complete	TRUE	Maintain
62287	Decompressio Percutaneous Diske	September 200	16		ASA		Reduce 99	Site of Ser	Septembe	090	9.03	NA	6.85	1.07	166	FALSE		FALSE					TRUE	PE Only
62290	Injection proc Injection for discogr	April 2010	45		ASA, AAPN	3.00, CPT /	Different F	October 2(	000	3	7.65	1.51	0.27	7115	TRUE	Mar 2011	Yes	FALSE				TRUE	Maintain
62302	Myelography \ Myelography	April 2014	17		ACR, ASNR	2.29	Codes Rep	October 2(	000	2.29	5.30	1.00	0.20	4191	FALSE		TRUE	Joint Workgroup request:	October 2(	21	Complete	TRUE	Decrease
62303	Myelography \ Myelography	April 2014	17		ACR, ASNR	2.29	Codes Rep	October 2(	000	2.29	5.43	1.00	0.20	411	FALSE		TRUE	Joint Workgroup request:	October 2(	21	Complete	TRUE	Decrease
62304	Myelography \ Myelography	April 2014	17		ACR, ASNR	2.25	Codes Rep	October 2(	000	2.25	5.25	0.99	0.20	18417	FALSE		TRUE	Joint Workgroup request:	October 2(	21	Complete	TRUE	Decrease
62305	Myelography \ Myelography	April 2014	17		ACR, ASNR	2.35	Codes Rep	October 2(	000	2.35	5.82	1.03	0.20	6616	FALSE		TRUE	Joint Workgroup request:	October 2(	21	Complete	TRUE	Decrease
62310	Injection(s), of Epidural Injections	October 2015	10	RUC	AAPM, AA		Deleted fr	CMS High	January 2012						FALSE		TRUE	In the NPRM for 2015, CN	May 2015	15	Complete	TRUE	Deleted from CPT
62311	Injection(s), of Epidural Injections	October 2015	10	RUC	AAPM, AA		Deleted fr	CMS High	September 2011						FALSE		TRUE	In the NPRM for 2015, CN	May 2015	15	Complete	TRUE	Deleted from CPT

62318	Injection(s), in	Epidural Injections	October 2015	10		RUC	AAPM, AA	Deleted fr	CMS High	January 2012									FALSE			TRUE	In the NPRM for 2015, CM	May 2015	15	Complete	TRUE	Deleted from CPT					
62319	Injection(s), in	Epidural Injections	October 2015	10		RUC	AAPM, AA	Deleted fr	CMS High	January 2012									FALSE			TRUE	In the NPRM for 2015, CM	May 2015	15	Complete	TRUE	Deleted from CPT					
62320	Injection(s), of	Epidural Injections	October 2015	10		RUC	AANS, AA	1.80	Final Rule	May 2015	000	1.8	2.89	0.87	0.22	5631	FALSE			FALSE		May 2015	15	Complete	TRUE	Decrease					
62321	Injection(s), of	Epidural Injections	October 2015	10		RUC	AANS, AA	1.95	Final Rule	May 2015	000	1.95	5.82	1.00	0.19	217240	FALSE			FALSE		May 2015	15	Complete	TRUE	Decrease					
62322	Injection(s), of	Epidural Injections	October 2015	10		RUC	AANS, AA	1.55	Final Rule	May 2015	000	1.55	2.55	0.65	0.17	42693	FALSE			FALSE		May 2015	15	Complete	TRUE	Decrease					
62323	Injection(s), of	Epidural Injections	October 2015	10		RUC	AANS, AA	1.80	Final Rule	May 2015	000	1.8	5.88	0.92	0.17	699990	FALSE			FALSE		May 2015	15	Complete	TRUE	Decrease					
62324	Injection(s), in	Epidural Injections	October 2015	10		RUC	AANS, AA	1.89	Final Rule	May 2015	000	1.89	2.12	0.56	0.15	19559	FALSE			FALSE		May 2015	15	Complete	TRUE	Decrease					
62325	Injection(s), in	Epidural Injections	October 2015	10		RUC	AANS, AA	2.20	Final Rule	May 2015	000	2.2	5.21	0.82	0.21	1225	FALSE			FALSE		May 2015	15	Complete	TRUE	Decrease					
62326	Injection(s), in	Epidural Injections	October 2015	10		RUC	AANS, AA	1.78	Final Rule	May 2015	000	1.78	2.31	0.58	0.15	4644	FALSE			FALSE		May 2015	15	Complete	TRUE	Decrease					
62327	Injection(s), in	Epidural Injections	October 2015	10		RUC	AANS, AA	1.90	Final Rule	May 2015	000	1.9	5.78	0.92	0.19	1995	FALSE			FALSE		May 2015	15	Complete	TRUE	Decrease					
62328	Spinal punctur	Lumbar Puncture	January 2019	09				1.95	Different F	Septembe	000	1.73	5.71	0.62	0.23		FALSE			FALSE		Septembe	24	Complete	TRUE	Increase					
62329	Spinal punctur	Lumbar Puncture	January 2019	09				2.25	Different F	Septembe	000	2.03	7.22	0.82	0.44		FALSE			FALSE		Septembe	24	Complete	TRUE	Increase					
62350	Implantation, r	Intrathecal Epidural	October 2010	67			AAPM, AA	6.05	Site of Ser	Septembe	010	6.05	NA	4.53	1.15	5884	FALSE			FALSE					TRUE	Decrease					
62355	Removal of pr	Intrathecal Epidural	October 2010	67			AAPM, AA	4.35	Site of Ser	Septembe	010	3.55	NA	3.71	0.76	1056	FALSE			FALSE					TRUE	Decrease					
62360	Implantation o	Intrathecal Epidural	October 2010	67			AAPMR, A	4.33	Site of Ser	April 2008	010	4.33	NA	4.12	0.99	242	FALSE			FALSE					TRUE	Decrease					
62361	Implantation o	Intrathecal Epidural	October 2010	67			AAPM, AA	5.65	Site of Ser	April 2008	010	5	NA	5.90	1.85	36	FALSE			FALSE					TRUE	Decrease					
62362	Implantation o	Intrathecal Epidural	October 2010	67			AAPM, AA	6.10	Site of Ser	Septembe	010	5.6	NA	4.53	1.24	8146	FALSE			FALSE					TRUE	Decrease					
62365	Removal of sul	Intrathecal Epidural	October 2010	67			AAPMR, A	4.65	Site of Ser	Septembe	010	3.93	NA	3.88	0.93	1266	FALSE			FALSE					TRUE	Decrease					
62367	Electronic anal	Electronic Analysis Ir	April 2018	14			AAPM, AA	New PE in	Different F	October 2(	XXX	0.48	0.39	0.19	0.05	10982	FALSE			TRUE	Identified through the Co	October 2(	49	Complete	TRUE	Maintain					
62368	Electronic anal	Electronic Analysis Ir	April 2018	14			AAPM, AA	New PE in	Different F	October 2(	XXX	0.67	0.55	0.27	0.09	43410	FALSE			TRUE	Identified through the Co	October 2(	49	Complete	TRUE	Decrease					
62369	Electronic anal	Electronic Analysis Ir	April 2018	14			AAPM, AA	New PE in	Codes Rep	October 2(	XXX	0.67	2.09	0.28	0.09	31581	FALSE			TRUE		October 2(	49	Complete	TRUE	Decrease					
62370	Electronic anal	Electronic Analysis Ir	April 2018	14			AAPM, AA	New PE in	Codes Rep	October 2(	XXX	0.9	1.90	0.36	0.10	101707	FALSE			TRUE		October 2(	49	Complete	TRUE	Decrease					
63020	Laminotomy (h	Lumbar Laminotomy	January 2022		January 2(	RUC	AAOS, ISA	Survey	Site of Ser	January 2(	090	16.2	NA	13.17	4.87	1345	FALSE			FALSE					FALSE							
63030	Laminotomy (h	Lumbar Laminotomy	January 2021	29	January 2(	RUC	AANS, AA	Survey	Pre-Time A	January 2(	090	13.18	NA	11.67	3.96	27404	FALSE			TRUE	CPT code 63030 was iden	September 2021		CCA rejecte	FALSE	Maintain					
63035	Laminotomy (h	Lumbar Laminotomy	January 2022		January 2(	RUC	AANS, AA	Survey	Site of Ser	January 2(	ZZZ	3.15	NA	1.56	0.93	6873	FALSE			FALSE					FALSE							
63042	Laminotomy (h	RAW	September 201	21			AANS, AA	Maintain v	Pre-Time A	January 2(	090	18.76	NA	14.29	5.17	10851	FALSE			FALSE					TRUE	Maintain					
63045	Laminectomy,	Laminectomy	September 201	16		RUC	Review work an	17.95	CMS Requ	November	090	17.95	NA	14.22	5.84	10977	FALSE			FALSE					TRUE	Maintain					
63046	Laminectomy,	Laminectomy	September 201	16		RUC	Review work an	17.25	CMS Requ	November	090	17.25	NA	13.73	5.30	4057	FALSE			FALSE					TRUE	Maintain					
63047	Laminectomy,	Laminectomy	January 2013	24			NASS, AA	15.37	CMS High	Septembe	090	15.37	NA	12.73	4.53	101838	FALSE			FALSE					TRUE	Maintain					
63048	Laminectomy,	Laminectomy	January 2013	24			NASS, AA	3.47	CMS High	January 2(	ZZZ	3.47	NA	1.72	1.02	128927	FALSE			FALSE					TRUE	Maintain					
63056	Transpedicular	RAW	October 2015	21		RAW	NASS, AA	Review ac	CMS Faste	October 2(	090	21.86	NA	15.52	6.63	6048	TRUE	Oct 2009	Yes	TRUE	The specialty noted that t	February 2010		Complete	TRUE	Maintain					
63075	Discectomy, ar	Arthrodesis Includin	February 2010	5			NASS, AA	19.60	Codes Rep	February 2	090	19.6	NA	14.62	5.84	428	FALSE			TRUE	Referred to the CPT Edito	October 2(	21	Complete	TRUE	Maintain					
63076	Discectomy, ar	Arthrodesis Includin	February 2010	5			NASS, AA	4.04	Codes Rep	orted Toge	ZZZ	4.04	NA	1.99	1.15	313	FALSE			FALSE					TRUE	Maintain					
63090	Vertebral corp	Vertebral Corpecton	January 2017	30	October 2(	RAW	AAOS, AA	Review ac	Codes Rep	January 2(	090	30.93	NA	19.02	7.77	719	FALSE			TRUE	In January 2015 the Joint	Septembe	20	yes	FALSE							
63620	Stereotactic ra	Stereotactic Radiosu	February 2009	38				15.50	CMS Requ	NA	090	15.6	NA	11.77	5.77	492	FALSE			FALSE					TRUE	Decrease					
63621	Stereotactic ra	Stereotactic Radiosu	February 2009	38				4.00	CMS Requ	NA	ZZZ	4	NA	1.92	1.47	160	FALSE			FALSE					TRUE	Decrease					
63650	Percutaneous	Percutaneous implai	October 2020	24			AAPM, AA	7.20. New	Site of Ser	Septembe	010	7.15	58.56	4.24	0.76	92083	FALSE			FALSE					TRUE	Decrease					
63655	Laminectomy f	Neurostimulator (Sp	April 2009	17			NASS, AA	11.43	CMS Faste	October 2(	090	10.92	NA	10.29	3.48	8801	FALSE			FALSE					TRUE	Maintain					
63660	Deleted from (	Neurostimulator (Sp	April 2009	17			AAPM, AA	Deleted fr	Site of Ser	September 2007							FALSE			TRUE	The RUC recommend tha	October 2(	19	Code Delete	TRUE	Deleted from CPT					
63661	Removal of spi	Neurostimulator (Sp	April 2009	17			ISIS, NASS,	5.03	Site of Ser	April 2008	010	5.08	14.23	3.61	0.90	3832	FALSE			FALSE					TRUE	Decrease					
63662	Removal of spi	Neurostimulator (Sp	April 2009	17			ISIS, NASS,	10.87	Site of Ser	April 2008	090	11	NA	10.47	3.55	2414	FALSE			FALSE					TRUE	Decrease					
63663	Revision incluc	Neurostimulator (Sp	April 2009	17			ISIS, NASS,	70	Site of Ser	April 2008	010	7.75	17.85	4.47	1.04	1584	FALSE			FALSE					TRUE	Decrease					
63664	Revision incluc	Neurostimulator (Sp	April 2009	17			ISIS, NASS,	11.39	Site of Ser	April 2008	090	11.52	NA	10.73	3.76	692	FALSE			FALSE					TRUE	Decrease					
63685	Insertion or re	Neurostimulators	January 2021	29	January 2(	RAW	AAPM, AA	Review ac	Site of Ser	Septembe	010	5.19	NA	4.42	1.07	29921	TRUE			FALSE					FALSE	Decrease					
63688	Revision or rer	Neurostimulators	February 2008	I			AAPM, AA	5.25	Site of Ser	Septembe	010	5.3	NA	4.54	1.13	8593	FALSE			FALSE					TRUE	Decrease					
64400	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAN, AAPI	1.00	Added as p	October 2(	000	0.75	2.40	0.53	0.19	36483	FALSE			FALSE					TRUE	Decrease					
64405	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAN, AAPI	0.94	CMS 000-D	July 2016	000	0.94	1.04	0.42	0.21	134871	FALSE			FALSE					TRUE	Maintain					
64408	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, NA	0.90	Added as p	October 2(	000	0.75	1.44	0.43	0.10	538	FALSE			FALSE					TRUE	Decrease					
64412	Injection, anes	Anesthetic Injection	April 2014	36			AAN, ASA,	Deleted fr	High Volur	April 2013							TRUE	FAQ Sept 2	Yes	TRUE	In April 2013, CPT code 64	October 2(	21	Complete	TRUE	Deleted from CPT					
64415	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AS/	1.50	CMS Faste	October 2(	000	1.35	1.89	0.38	0.11	199150	TRUE	Dec 2011 i	Yes	TRUE	During the October 2018	May 2021	14	complete	TRUE	Increase					
64416	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AS/	1.80	Site of Ser	Septembe	000	1.48	NA	0.27	0.13	17912	FALSE			TRUE	During the October 2018	May 2021	14	complete	TRUE	Decrease					
64417	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AS/	1.31	part of Ne	October 2(	000	1.27	2.76	0.39	0.11	15765	FALSE			TRUE	During the October 2018	May 2021	14	complete	TRUE	Decrease					
64418	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, SIS	1.10	Harvard V	October 2(	000	1.1	1.38	0.44	0.14	31818	FALSE			FALSE					TRUE	Decrease					
64420	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AA	1.18	Added as p	October 2(	000	1.08	1.75	0.54	0.11	3812	FALSE			FALSE					TRUE	Maintain					
64421	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AA	0.60	Added as p	October 2(	ZZZ	0.5	0.44	0.18	0.05	18541	FALSE			FALSE					TRUE	Decrease					
64425	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AA	1.19	Added as p	October 2(	000	1	2.27	0.51	0.11	7963	FALSE			FALSE					TRUE	Decrease					
64430	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AC	1.15	Added as p	October 2(	000	1	1.73	0.48	0.13	4007	FALSE			FALSE					TRUE	Decrease					
64435	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AC	0.75	Added as p	October 2(	000	0.75	1.47	0.40	0.13	38	FALSE			FALSE					TRUE	Decrease					
64445	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AA	1.39	CMS Faste	October 2(	000	1	2.68	0.47	0.10	130719	TRUE	Dec 2011 i	Yes	FALSE					TRUE	Decrease					
64446	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AS/	1.75	Site of Ser	February 2	000	1.36	NA	0.25	0.11	5880	FALSE			TRUE	During the October 2018	May 2021	14	complete	TRUE	Decrease					
64447	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AS/	1.34	CMS Faste	October 2(	000	1.1	1.45	0.35	0.09	282703	TRUE	Dec 2011 i	Yes	TRUE	During the October 2018	May 2021	14	complete	TRUE	Decrease					
64448	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AS/	1.68	Site of Ser	February 2	000	1.41	NA	0.25	0.11	40188	FALSE			TRUE	During the October 2018	May 2021	14	complete	TRUE	Increase					
64449	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, NA	1.55	Site of Ser	Septembe	000	1.27	NA	0.42	0.13	1957	FALSE			TRUE	The RUC recommended c	February 2	31	Complete	TRUE	Decrease					
64450	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AA	0.75	Harvard V	October 2(	000	0.75	1.45	0.40	0.09	467316	TRUE	Jan 2013	Yes	FALSE					TRUE	Maintain					
64451	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AA	1.52	Added as p	October 2(	000	1.52	4.91	0.63	0.15		FALSE			FALSE					TRUE	Maintain					
64454	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, NA	1.52	Added as p	October 2(	000	1.52	4.89	0.71	0.15		FALSE			FALSE					TRUE	Maintain					
64455	Injection(s), ar	Somatic Nerve Injec	October 2021	05			AAPM, AP	0.75	High Volur	October 2(	000	0.75	0.62	0.18	0.05	74450	FALSE			FALSE					TRUE	Maintain					
64461	Paravertebral l	Paravertebral Block	April 2015	10			ASA	CPT Assist	New code	April 2015	000	1.75	2.05	0.35	0.15	4096	TRUE	Jan 2016	Yes	FALSE					TRUE	Not Part of RAW					
64462	Paravertebral l	Paravertebral Block	April 2015	10			ASA	CPT Assist	New code	April 2015	ZZZ	1.1	0.99	0.24	0.09	1483	TRUE	Jan 2016	Yes	FALSE					TRUE	Not Part of RAW					
64463	Paravertebral l	Paravertebral Block	April 2015	10			ASA	CPT Assist	New code	April 2015	000	1.9	4.59	0.35	0.15	1514	TRUE	Jan 2016	Yes	FALSE					TRUE	Not Part of RAW					
64470	Deleted from (	Injection Anesthetic	April 2008	57			ASA, NASS	Deleted fr	High Volur	April 2008							FALSE			TRUE	The RUC recommended t	February 2	28	Code Delete	TRUE	Deleted from CPT					
64472	Deleted from (	Injection Anesthetic	April 2008	57			ASA, NASS	Deleted fr	High Volur	February 2008							FALSE			TRUE	The RUC recommended t	February 2	28	Code Delete	TRUE	Deleted from CPT					
64475	Deleted from (	Injection Anesthetic	April 2008	57			ASA, NASS	Deleted fr	High Volur	April 2008							FALSE			TRUE	The RUC recommended t	February 2	28	Code Delete	TRUE	Deleted from CPT					
64476	Deleted from (	Injection Anesthetic	April 2008	57			ASA, NASS	Deleted fr	High Volur	April 2008							FALSE			TRUE	The RUC recommended t	February 2	28	Code Delete	TRUE	Deleted from CPT					
64479	Injection(s), ar	Injection Anesthetic	October 2009	05			AAPM, ISIS	2.29	CMS Faste	October 2(	000	2.29	5.38	1.32	0.21	44367	FALSE			TRUE	The RUC recommended t	June 2009	19	CPT Editoria	TRUE	Increase					
64480	Injection(s), ar	Injection Anesthetic	October 2009	05			AAPM, ISIS	1.20	CMS Faste	October 2(	ZZZ	1.2	2.66	0.49	0.13	19219	FALSE			TRUE	The RUC recommended t	June 2009	19	CPT Editoria	TRUE	Decrease					
64483	Injection(s), ar	Injection of Anesthe	October 2009	05			AAPM, ISIS	1.90	CMS Faste	October 2(	000	1.9	5.26	1.18	0.17	1044547	FALSE			TRUE	The RUC recommended t	June 2009	19	CPT Editoria	TRUE	Decrease					
64484	Injection(s), ar	Injection of Anesthe	October 2009	05			AAPM, ISIS	1.00	CMS Faste	October 2(	ZZZ	1	2.19	0.42	0.10	431178	FALSE			TRUE	The Workgroup recomme	June 2009	19	CPT Editoria	TRUE	Decrease					
64490	Injection(s), di	Facet Joint Injection	April 2009	18			ASA, NASS	1.82	High Volume Growth		000	1.82	3.71	1.08	0.19	265103	FALSE			FALSE					TRUE	Decrease					
64491	Injection(s), di	Facet Joint Injection	April 2009	18			ASA, NASS	1.16	High Volume Growth		ZZZ	1.16	1.60	0.47	0.13	239462	FALSE			FALSE					TRUE	Decrease					

64492	Injection(s), di	Facet Joint Injection	April 2009	18			ASA, NASS	1.16	High Volume Growth	ZZZ	1.16	1.61	0.50	0.13	156746	FALSE			FALSE						TRUE	Decrease
64493	Injection(s), di	Facet Joint Injection	April 2009	18			ASA, NASS	1.52	High Volume Growth	000	1.52	3.58	0.97	0.15	901171	FALSE			FALSE						TRUE	Decrease
64494	Injection(s), di	Facet Joint Injection	April 2009	18			ASA, NASS	1.00	High Volume Growth	ZZZ	1	1.59	0.41	0.10	809666	FALSE			FALSE						TRUE	Decrease
64495	Injection(s), di	Facet Joint Injection	April 2009	18			ASA, NASS	1.00	High Volume Growth	ZZZ	1	1.59	0.43	0.10	456363	FALSE			FALSE						TRUE	Decrease
64510	Injection, anes	Fluroscopy	April 2009	27			ASA, ISIS, A	New PE in	CMS Requ	April 2009	000	1.22	3.00	0.90	0.13	6436	FALSE			FALSE						TRUE	PE Only
64520	Injection, anes	Fluroscopy	April 2009	27			ASA, ISIS, A	PE Review	CMS Requ	April 2009	000	1.35	5.34	0.97	0.14	18919	FALSE			FALSE						TRUE	PE Only
64550	Application of	Percutaneous Neurc	January 2017	29			AANS, CNS	Deleted fr	Final Rule	January 2017							FALSE			TRUE	In September 2016, the C	June 2017	12	yes	TRUE	Deleted from CPT
64553	Percutaneous	Percutaneous Neurc	January 2017	15	RUC		AANS, CNS	6.13	Final Rule	July 2014	010	6.13	64.69	3.71	0.77	484	FALSE			TRUE	The RUC discussed the co	Septembe	36	yes	TRUE	Increase
64555	Percutaneous	Percutaneous Neurc	January 2019	37			AANS, CNS	5.76. Artic	High Volur	February 2	010	5.76	58.65	3.42	0.77	3342	TRUE	Jan 2016	Yes	TRUE	The RUC discussed the co	Septembe	36	yes	TRUE	Increase
64561	Percutaneous	Percutaneous Neurc	October 2020	24			AANS, CNS	5.44. 9921	CMS Faste	October 2(	010	5.44	16.70	2.74	0.69	14987	FALSE			FALSE		Septembe	36	yes	TRUE	Decrease
64565	Percutaneous	Percutaneous Neurc	January 2017	15			AANS, CNS	Deleted fr	Final Rule	January 2017							FALSE			FALSE		Septembe	36	yes	TRUE	Deleted from CPT
64566	Posterior tibial	Posterior Tibial Neu	January 2019	37			ACOG, AU	0.60	CMS Requ	July 2013	000	0.6	3.05	0.21	0.09	201680	FALSE			FALSE						TRUE	Maintain
64568	Open implanta	Vagus Nerve Stimul	February 2010	14			AANS/CNS	11.19	Site of Ser	February 2	090	9	NA	6.98	2.22	1002	FALSE			FALSE		October 2(	35		TRUE	Decrease
64573	Deleted from (	Neurosurgical Proce	February 2009	28			AANS/CNS	Deleted fr	Site of Ser	September 2007							FALSE			TRUE	In Feb 2009, the specialty	October 2(	35	Code Delete	TRUE	Deleted from CPT
64581	Open implanta	Urological Procedur	January 2016	54			AUA	12.20. 992	Site of Ser	Septembe	090	12.2	NA	5.51	1.59	10284	FALSE			FALSE						TRUE	Decrease
64590	Insertion or re	RAW	January 2018	31			ACOG, AUA		Harvard-V	October 2(	010	2.45	5.24	1.92	0.34	12197	FALSE			TRUE	In October 2017, this service was identified as I			Code incorr	TRUE	Remove from screen
64615	Chemodenervation of muscle(s); m		October 2020	23			AAN, AAN	Maintain	High Volur	October 2(	010	1.85	2.08	1.18	0.59	143888	FALSE			FALSE						TRUE	Maintain
64622	Destruction by	Fluroscopy	April 2009	27			ASA, ISIS, A	PE Review	CMS Requ	April 2008							FALSE			TRUE	The Executive Committee	June 2008	EC & 7	Code Delete	TRUE	Deleted from CPT
64623	Destruction by	Destruction by Neur	April 2008	57			ASA, NASS	Deleted fr	High Volur	February 2008							FALSE			TRUE	The Executive Committee	June 2008	EC & 7	Code Delete	TRUE	Deleted from CPT
64626	Destruction by	Fluroscopy	April 2009	27			ASA, ISIS, A	PE Review	CMS Requ	April 2008							FALSE			TRUE	The Executive Committee	June 2008	EC & 7	Code Delete	TRUE	Deleted from CPT
64627	Destruction by	Destruction by Neur	April 2008	57			ASA, NASS	Deleted fr	High Volur	April 2008							FALSE			TRUE	The Executive Committee	June 2008	EC & 7	Code Delete	TRUE	Deleted from CPT
64633	Destruction by	Destruction by Neur	October 2020	17			ASA, AAPN	3.42	Work Neu	Septembe	010	3.84	8.33	2.35	0.37	86013	TRUE	February 2	Yes	TRUE	In February 2011, the CPT	May 2015	20	complete	TRUE	Decrease
64634	Destruction by	Destruction by Neur	October 2020	17			ASA, AAPN	1.32	Work Neu	Septembe	ZZZ	1.32	4.21	0.53	0.13	135589	TRUE	February 2	Yes	TRUE	In February 2011, the CPT	May 2015	20	complete	TRUE	Maintain
64635	Destruction by	Destruction by Neur	October 2020	17			ASA, AAPN	3.42	Work Neu	Septembe	010	3.78	8.28	2.33	0.36	358450	TRUE	February 2	Yes	TRUE	In February 2011, the CPT	May 2015	20	complete	TRUE	Decrease
64636	Destruction by	Destruction by Neur	October 2020	17			ASA, AAPN	1.16	Work Neu	Septembe	ZZZ	1.16	3.89	0.47	0.11	539040	TRUE	Feb 2015	Yes	TRUE	In February 2011, the CPT	May 2015	20	complete	TRUE	Maintain
64640	Destruction by	Injection Treatment	September 201	25			ASAM AAF	1.23. Rem	Site of Ser	Septembe	010	1.98	5.34	1.29	0.19	184562	FALSE			FALSE						TRUE	Decrease
64708	Neuroplasty, n	Neuroplasty – Leg o	October 2010	69			AOFAS, AS	6.36	Site of Ser	Septembe	090	6.36	NA	7.44	1.21	4356	FALSE			FALSE						TRUE	Maintain
64712	Neuroplasty, n	Neuroplasty – Leg o	October 2009	40			AOFAS, AS	Remove fr	Site of Ser	Septembe	090	8.07	NA	7.85	1.61	705	FALSE			TRUE	The specialty society has	February 2	32	Editorial Ch	TRUE	Remove from Screen
64831	Suture of digit	Neurorrhaphy – Fing	October 2010	70			AAOS, ASP	9.16	Site of Ser	Septembe	090	9.16	NA	9.58	1.62	878	FALSE			FALSE						TRUE	Decrease
65105	Enucleation of	Ophthalmologic Pro	September 200	16			AAO	Reduce 99	Site of Ser	Septembe	090	9.93	NA	16.80	0.74	835	FALSE			FALSE						TRUE	PE Only
65205	Removal of for	Removal of Foreign	April 2017	19			AAO, AOA	0.49	CMS 000-D	July 2016	000	0.49	0.33	0.32	0.04	26275	FALSE			FALSE						TRUE	Decrease
65210	Removal of for	Removal of Foreign	April 2017	19			AAO, AOA	0.75	CMS 000-D	July 2016	000	0.61	0.49	0.41	0.04	25202	FALSE			FALSE						TRUE	Decrease
65222	Removal of for	Removal of Foreign	September 201	26			AAO, AOA	0.93	Harvard V	April 2011	000	0.84	1.09	0.58	0.05	24544	FALSE			FALSE						TRUE	Maintain
65285	Repair of lacer	Repair of Eye Woun	February 2011	8			AAO	16.00	Site of Ser	Septembe	090	15.36	NA	15.46	1.15	704	FALSE			FALSE						TRUE	Decrease
65780	Ocular surface	Ocular Reconstructi	April 2015	31			AAO	8.80	CMS Faste	October 2(	090	7.81	NA	10.94	0.59	1974	TRUE	Jun 2009	Yes	FALSE						TRUE	Decrease
65800	Paracentesis o	Paracentesis of the I	April 2012	21			AAO	1.53	Harvard V	Septembe	000	1.53	1.82	0.95	0.13	20137	FALSE			TRUE	Sept 2011 AAO stated tha	October 2(	19	Complete	TRUE	Decrease
65805	Paracentesis o	Paracentesis of the I	April 2012	21			AAO	Deleted fr	Harvard V	April 2011							FALSE			TRUE	Sept 2011 AAO stated tha	October 2(	19	Complete	TRUE	Deleted from CPT
65855	Trabeculoplast	Trabeculoplasty by L	April 2015	11	RUC		AAO	3.00	010-Day G	January 2(	010	3	3.96	2.71	0.22	143167	FALSE			TRUE	Referred to CPT to exclud	February 2	28	Complete	TRUE	Decrease
66170	Fistulization of	Glaucoma Surgery	April 2015	32	RUC		AAO	13.94	090-Day G	January 2(	090	13.94	NA	16.61	1.03	6957	FALSE			FALSE						TRUE	Decrease
66172	Fistulization of	Glaucoma Surgery	April 2015	32	RUC		AAO	14.81	090-Day G	January 2(	090	14.84	NA	18.54	1.10	3104	FALSE			FALSE						TRUE	Decrease
66174	Transluminal d	Dilation of Aqueous	January 2021	15			AAO	8.53	New Techi	April 2010	090	12.85	NA	13.35	0.96	10214	FALSE			TRUE	In January 2020, the RUC	October 2(	36	complete	TRUE	Decrease
66175	Transluminal d	Dilation of Aqueous	January 2021	15			AAO	10.25	New Techi	October 2(	090	13.6	NA	13.88	1.02	223	FALSE			FALSE						TRUE	Decrease
66179	Aqueous shun	Aqueous Shunt	January 2014	12			AAO	14.00	Harvard-V	January 2(	090	14	NA	16.15	1.03	802	FALSE			TRUE		October 2(	24	Complete	TRUE	Decrease
66180	Aqueous shun	Aqueous Shunt	January 2020	37			AAO	Maintain.	Harvard-V	October 2(	090	15	NA	16.76	1.13	10715	FALSE			TRUE	In April 2013, the Americ	October 2(	24	Complete	TRUE	Decrease
66183	Insertion of an	Aqueous Shunt	January 2020	37			AAO	Maintain.	Harvard-V	January 2(	090	13.2	NA	15.57	0.99	4674	FALSE			FALSE						TRUE	Maintain
66184	Revision of aq	Aqueous Shunt	January 2014	12			AAO	9.58	Harvard-V	January 2(	090	9.58	NA	12.53	0.71	594	FALSE			TRUE		October 2(	24	Complete	TRUE	Decrease
66185	Revision of aq	Aqueous Shunt	January 2020	37			AAO	Maintain.	Harvard-V	October 2(	090	10.58	NA	13.16	0.78	1600	FALSE			TRUE	In April 2013, the Americ	October 2(	24	Complete	TRUE	Increase
66711	Ciliary body de	Cyclophotocoagulati	January 2019	11			AAO	6.36	Codes Rep	October 2(	090	5.62	NA	8.58	0.43	7616	FALSE			TRUE	In October 2017, maintair	May 2018	26	Yes	TRUE	Decrease
66761	Iridotomy/irid	Iridotomy	January 2020	37			AAO	Maintain.	High IWPU	February 2	010	3	5.56	3.60	0.22	67836	FALSE			TRUE	In April 2009 the Workgrc	February 2	33	Revised	TRUE	Decrease
66821	Discission of secondary membrano		February 2011	41			AAO	Maintain	MPC List	October 2(	090	3.42	6.06	5.36	0.25	685933	FALSE			FALSE						TRUE	Maintain
66982	Extracapsular (	Cataract Removal wi	January 2021	16			AAO	10.25	High IWPU	Septembe	090	10.25	NA	10.53	0.74	159924	TRUE	Sep 2009	Yes	FALSE						TRUE	Decrease
66983	Intracapsular c	Cyclophotocoagulati	January 2019	11				Contractor	Codes Rep	January 2(	090	0	0.00	0.00	0.00	93	FALSE			FALSE						TRUE	Contractor Price
66984	Extracapsular (	Cataract Removal wi	January 2021	16			AAO	7.35	High IWPU	February 2	090	7.35	NA	7.83	0.53	1694951	FALSE			TRUE	In October 2017, maintair	May 2018	26	Yes	TRUE	Decrease
66987	Extracapsular (	Cataract Removal wi	January 2021	16			AAO	13.15	Codes Rep	January 2(	090	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	Decrease
66988	Extracapsular (	Cyclophotocoagulati	January 2019	11				10.25	Codes Rep	January 2(	090	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	Decrease
66989	Extracapsular (	Cataract Removal wi	January 2021	16			AAO	12.13	High Volur	January 2021							FALSE			FALSE	At the April 2019 RUC me	October 2(	37	complete	TRUE	Maintain
66991	Extracapsular (	Cataract Removal wi	January 2021	16			AAO	9.23	High Volur	January 2021							FALSE			FALSE	At the April 2019 RUC me	October 2(	37	complete	TRUE	Maintain
67028	Intravitreal inje	Treatment of Retina	April 2019	14			AAO, ASRS	1.44	High Volur	February 2	000	1.44	1.75	1.11	0.11	3868836	FALSE			FALSE						TRUE	Maintain
67036	Vitrectomy, m	Vitrectomy	October 2013	11			AAO	12.13	Harvard-V	October 2(	090	12.13	NA	12.84	0.92	18016	FALSE			FALSE						TRUE	Decrease
67038	Deleted from (	Ophthalmological Pr	September 200	16			AAO	Deleted fr	Site of Ser	September 2007							FALSE			FALSE		February 2007			TRUE	Deleted from CPT
67039	Vitrectomy, m	Vitrectomy	October 2013	11			AAO	13.20	Site of Ser	Septembe	090	13.2	NA	13.50	0.99	3357	FALSE			FALSE						TRUE	Decrease
67040	Vitrectomy, m	Vitrectomy	October 2013	11			AAO	14.50	Site of Ser	Septembe	090	14.5	NA	14.31	1.10	8666	FALSE			FALSE						TRUE	Decrease
67041	Vitrectomy, m	Vitrectomy	October 2013	11			AAO	16.33	Harvard-V	October 2(	090	16.33	NA	15.44	1.24	13146	FALSE			FALSE						TRUE	Decrease
67042	Vitrectomy, m	Vitrectomy	October 2013	11			AAO	16.33	Harvard-V	October 2(	090	16.33	NA	15.44	1.24	26972	FALSE			FALSE						TRUE	Decrease
67043	Vitrectomy, m	Vitrectomy	October 2013	11			AAO	17.40	Harvard-V	October 2(	090	17.4	NA	16.10	1.30	373	FALSE			FALSE						TRUE	Decrease
67101	Repair of retin	Retinal Detachment	October 2015	11	RUC		AAO, ASRS	3.50	090-Day G	April 2015	010	3.5	5.95	4.45	0.26	343	FALSE			TRUE	In April 2015, the RUC rec	May 2015	21	Complete	TRUE	Decrease
67105	Repair of retin	Retinal Detachment	October 2015	11	RUC		AAO, ASRS	3.84	090-Day G	April 2015	010	3.39	4.98	4.29	0.25	3778	FALSE			TRUE	In April 2015, the RUC rec	May 2015	21	Complete	TRUE	Decrease
67107	Repair of retin	Retinal Detachment	April 2015	12			AAO	16.00. Red	Site of Ser	Septembe	090	16	NA	15.23	1.19	623	FALSE			FALSE	CPT codes 67108 amd 67	October 2(	23		TRUE	Decrease
67108	Repair of retin	Retinal Detachment	April 2015	12	RUC		AAO	17.13	Site of Ser	Septembe	090	17.13	NA	15.93	1.28	16523	FALSE			FALSE	CPT codes 67108 amd 67	October 2(	23		TRUE	Decrease
67110	Repair of retin	Retinal Detachment	April 2015	12			AAO	10.25. Ren	Site of Ser	Septembe	090	10.25	14.89	12.46	0.75	2305	FALSE			FALSE	CPT codes 67108 amd 67	October 2(	23		TRUE	Maintain
67112	Repair of retin	Retinal Detachment	April 2015	12			AAO	Deleted fr	090-Day G	April 2014							FALSE			TRUE	Added as part of the fami	October 2(	23	Complete	TRUE	Deleted from CPT
67113	Repair of com	Retinal Detachment	April 2015	12	RUC		AAO	19.00	090-Day G	January 2(	090	19	NA	17.96	1.44	12384	FALSE			FALSE	CPT codes 67108 amd 67	October 2(	23	Complete	TRUE	Decrease
67141	Prophylaxis of	Retinal Detachment	October 2020	08			AAO, ASRS	2.53	Harvard V	January 2(	090	6.15	8.63	7.41	0.45	1395	FALSE			TRUE	CPT code 67145 was iden	May 2020		complete	TRUE	Decrease
67145	Prophylaxis of	Retinal Detachment	October 2020	08			AAO, ASRS	2.53	Harvard V	October 2(	090	6.32	8.51	7.52	0.47	31865	FALSE			TRUE	CPT code 67145 was iden	May 2020		Complete	TRUE	Decrease
67210	Destruction of	Treatment of Retina	October 2010	13			AAO	6.36	High IWPU	February 2	090	6.36	8.14	7.54	0.47	56884	FALSE			TRUE	Code originally referred to CPT with request for			Complete	TRUE	Decrease
67220	Destruction of	Treatment of Retina	October 2010	13			AAO	6.36	High IWPU	February 2	090	6.36	8.62	7.54	0.47	3636	FALSE			TRUE	Code originally referred to CPT with request for			Complete	TRUE	Decrease
67225	Destruction of	Photodynamic Ther	February 2008	P			AAO	0.47	New Techi	Septembe	ZZZ	0.47	0.34	0.29	0.04	168	FALSE			FALSE						TRUE	Maintain
67228	Treatment of e	Treatment of Retina	October 2009	40			AAO	Remove fr	High IWPU	February 2	010	4.39	5.16	4.04	0.33	62152	FALSE			FALSE						TRUE	Remove from Screen
67255	Scleral reinfor	Aqueous Shunt	January 2014	12			AAO	10.17	Harvard-V	January 2(	090	8.38	NA	10.83	0.64	833	FALSE			TRUE		October 2(	24	Complete	TRUE	Maintain
67311	Strabismus sur	Strabismus Surgery	October 2020	18			AAO, AAP	5.93	ZZZ Global	April 2020	090	7.77	NA	8.90	0.59	4955	FALSE			FALSE						TRUE	Decrease

67312	Strabismus sur	Strabismus Surgery	October 2020	18		AAO, AAP	9.50	ZZZ Global	April 2020	090	9.66	NA	10.47	0.74	1514	FALSE			FALSE					TRUE	Decrease
67314	Strabismus sur	Strabismus Surgery	October 2020	18		AAO, AAP	5.93	ZZZ Global	April 2020	090	8.79	NA	10.32	0.65	2533	FALSE			FALSE					TRUE	Decrease
67316	Strabismus sur	Strabismus Surgery	October 2020	18		AAO, AAP	10.31	ZZZ Global	April 2020	090	10.93	NA	11.62	0.80	168	FALSE			FALSE					TRUE	Decrease
67318	Strabismus sur	Strabismus Surgery	October 2020	18		AAO, AAP	9.80	ZZZ Global	April 2020	090	9.12	NA	10.86	0.68	205	FALSE			FALSE					TRUE	Decrease
67320	Transposition	Strabismus Surgery	October 2020	18		AAO, AAP	3.00	ZZZ Global	October 20	ZZZ	5.4	NA	3.31	0.42	362	FALSE			FALSE					TRUE	Decrease
67331	Strabismus sur	Strabismus Surgery	October 2020	18		AAO, AAP	2.00	ZZZ Global	October 20	ZZZ	5.13	NA	3.15	0.39	902	FALSE			FALSE					TRUE	Decrease
67332	Strabismus sur	Strabismus Surgery	October 2020	18		AAO, AAP	3.50	ZZZ Global	October 20	ZZZ	5.56	NA	3.41	0.43	1753	FALSE			FALSE					TRUE	Decrease
67334	Strabismus sur	Strabismus Surgery	October 2020	18		AAO, AAP	2.06	ZZZ Global	October 20	ZZZ	5.05	NA	3.11	0.38	128	FALSE			FALSE					TRUE	Decrease
67335	Placement of a	Strabismus Surgery	October 2020	18		AAO, AAP	3.23	ZZZ Global	October 20	ZZZ	2.49	NA	1.52	0.19	1681	FALSE			FALSE					TRUE	Increase
67340	Strabismus sur	Strabismus Surgery	October 2020	18		AAO, AAP	5.00	ZZZ Global	October 20	ZZZ	6	NA	3.71	0.45	88	FALSE			FALSE					TRUE	Decrease
67500	Retrobulbar in	Injection – Eye	October 2017	11		AAO, ASRS	1.18	CMS 000-D	October 20	000	1.18	0.91	0.52	0.09	7903	FALSE			FALSE					TRUE	Decrease
67505	Retrobulbar in	Injection – Eye	October 2017	11		AAO, ASRS	1.18	CMS 000-D	October 20	000	1.18	1.26	0.82	0.09	140	FALSE			FALSE					TRUE	Decrease
67515	Injection of me	Injection – Eye	October 2017	11		AAO, ASRS	0.84	CMS 000-D	July 2016	000	0.75	0.69	0.56	0.05	24360	FALSE			FALSE					TRUE	Decrease
67820	Correction of t	Correction of Trichia	April 2016	29		AOA, AOA	0.32	CMS High	July 2015	000	0.32	0.27	0.31	0.02	222157	FALSE			FALSE					TRUE	Decrease
67914	Repair of ectro	Repair of Eyelid	April 2013	24		AAO	3.75	Harvard-V	October 20	090	3.75	10.51	5.40	0.30	1601	FALSE			FALSE					TRUE	Maintain
67915	Repair of ectro	Repair of Eyelid	April 2013	24		AAO	2.03	Harvard-V	October 20	090	2.03	7.26	3.54	0.15	332	FALSE			FALSE					TRUE	Decrease
67916	Repair of ectro	Repair of Eyelid	April 2013	24		AAO	5.48	Harvard-V	October 20	090	5.48	12.24	6.46	0.45	1895	FALSE			FALSE					TRUE	Maintain
67917	Repair of ectro	Repair of Eyelid	April 2013	24		AAO	5.93	Harvard-V	October 20	090	5.93	12.07	6.75	0.47	24678	FALSE			FALSE					TRUE	Decrease
67921	Repair of entro	Repair of Eyelid	April 2013	24		AAO	3.47	Harvard-V	October 20	090	3.47	10.56	5.25	0.26	3614	FALSE			FALSE					TRUE	Maintain
67922	Repair of entro	Repair of Eyelid	April 2013	24		AAO	2.03	Harvard-V	October 20	090	2.03	6.95	3.52	0.15	100	FALSE			FALSE					TRUE	Decrease
67923	Repair of entro	Repair of Eyelid	April 2013	24		AAO	5.48	Harvard-V	October 20	090	5.48	12.25	6.48	0.43	1300	FALSE			FALSE					TRUE	Decrease
67924	Repair of entro	Repair of Eyelid	April 2013	24		AAO	5.93	Harvard-V	October 20	090	5.93	12.90	6.76	0.46	11149	FALSE			FALSE					TRUE	Maintain
68040	Expression of	Treatment of Eyelid	September 201	51		AAO	Revised pa	High Volum	February 2	000	0.85	0.91	0.49	0.04	6702	FALSE			TRUE	AAO to develop CPT Assi	February 2	18	Complete	TRUE	Maintain
68200	Subconjunctiva	Subconjunctival Inje	October 2013	18		AAO	0.49	Harvard V	April 2011	000	0.49	0.68	0.46	0.04	8059	FALSE			FALSE					TRUE	Maintain
68801	Dilation of lacr	Dilation and Probing	January 2015	23		AAO, AOA	1.00	010-Day G	January 20	010	0.82	1.91	1.39	0.05	27980	FALSE			FALSE					TRUE	Maintain
68810	Probing of nas	Dilation and Probing	January 2015	23		AAO, AOA	1.54	Site of Ser	Septembe	010	1.54	3.07	2.02	0.13	28019	FALSE			FALSE					TRUE	Decrease
68811	Probing of nasolacrimal duct, with (		January 2015	23		AAO, AOA	2.03	010-Day G	Septembe	010	1.74	NA	2.01	0.14	451	FALSE			FALSE					TRUE	Decrease
68815	Probing of nas	Dilation and Probing	January 2015	23		AAO, AOA	3.00	010-Day G	January 20	010	2.7	8.61	3.49	0.21	8129	FALSE			FALSE					TRUE	Decrease
68816	Probing of nasolacrimal duct, with (		January 2015	23		AAO, AOA	2.35	010-Day G	Septembe	010	2.1	23.29	2.26	0.16	248	FALSE			FALSE					TRUE	Decrease
69100	Biopsy externa	Biopsy of Ear	April 2009	28		AAD	0.81	CMS Faste	October 20	000	0.81	2.01	0.46	0.09	164973	FALSE			FALSE					TRUE	Maintain
69200	Removal foreig	Removal of Foreign	September 201	29		AAO-HNS	0.77	Harvard V	April 2011	000	0.77	1.51	0.49	0.11	59479	FALSE			FALSE					TRUE	Maintain
69210	Removal impa	Removal of Cerumen	January 2015	29		AAFP, AAC	0.58.	CMS High	Septembe	000	0.61	0.69	0.27	0.09	1589620	FALSE			TRUE	In January 2012, the RUC	October 20	19	Complete	TRUE	Decrease
69400	Eustachian tub	Eustachian Tube Pro	October 2013	18		AAO-HNS	Deleted fr	High Volum	October 2013							FALSE			TRUE	October 2013, the RUC re	February 2	41	Complete	TRUE	Deleted from CPT
69401	Eustachian tub	Eustachian Tube Pro	October 2013	18		AAO-HNS	Deleted fr	High Volum	April 2013							FALSE			TRUE	October 2013, the RUC re	February 2	41	Complete	TRUE	Deleted from CPT
69405	Eustachian tub	Eustachian Tube Pro	October 2013	18		AAO-HNS	Deleted fr	High Volum	October 2013							FALSE			TRUE	October 2013, the RUC re	February 2	41	Complete	TRUE	Deleted from CPT
69433	Tympanostom	Tympanostomy	September 201	30		AAO-HNS	1.57	Harvard V	April 2011	010	1.57	4.15	2.03	0.21	48248	FALSE			FALSE					TRUE	Maintain
69801	Labyrinthotom	Labyrinthotomy	October 2015	21		AAO-HNS	Review ac	CMS Faste	Septembe	000	2.06	4.22	1.26	0.27	24321	TRUE	May 2011	Yes	TRUE	The Workgroup previousl	Feb 2010	34	Revised	TRUE	Decrease
69802	Labyrinthotom	Labryinthotomy	April 2010	16		AAO-HNS	Deleted fr	CMS Fastest Growing / Site of Service Anomaly (99238-Only)								FALSE			TRUE	Prior to surveying this ser	Feburary 2	25	Code Delete	TRUE	Deleted from CPT
69930	Cochlear devic	Cochlear Device Imp	February 2008	M		AAO-HNS	17.60	Site of Ser	Septembe	090	17.73	NA	15.81	2.44	4267	FALSE			FALSE					TRUE	Maintain
70030	Radiologic exa	X-Ray of Eye	January 2020	28			0.18	CMS-Othe	January 20	XXX	0.18	0.74	NA	0.02	23756	FALSE			FALSE					TRUE	Increase
70100	Radiologic exa	RAW	October 2013	18			RUC to sub	High Volum	April 2013	XXX	0.18	0.92	NA	0.02	20165	FALSE			FALSE					TRUE	Maintain
70210	Radiologic exa	X-Ray Exam - Sinuses	January 2019	24		AAFP, ACP	0.20	CMS-Othe	October 20	XXX	0.17	0.75	NA	0.02	31748	FALSE			FALSE					TRUE	Increase
70220	Radiologic exa	X-Ray Exam - Sinuses	January 2019	24		AAFP, ACP	0.22	CMS-Othe	October 20	XXX	0.22	0.86	NA	0.02	59212	FALSE			FALSE					TRUE	Decrease
70250	Radiologic exa	X-Ray Exam – Skull	January 2019	25		ACR, ASNR	0.20	CMS-Othe	October 20	XXX	0.18	0.84	NA	0.02	45019	FALSE			FALSE					TRUE	Decrease
70260	Radiologic exa	X-Ray Exam – Skull	January 2019	25		ACR, ASNR	0.29	CMS-Othe	October 20	XXX	0.28	1.01	NA	0.02	9622	FALSE			FALSE					TRUE	Decrease
70310	Radiologic exa	RAW	October 2013	18			RUC to sub	High Volum	April 2013	XXX	0.16	0.95	NA	0.02	2217	FALSE			FALSE					TRUE	Maintain
70360	Radiologic exa	X-Ray Exam – Neck	January 2019	26		AAFP, ACP	0.20	CMS-Othe	October 20	XXX	0.18	0.72	NA	0.02	64675	FALSE			FALSE					TRUE	Increase
70371	Complex dyna	Laryngography	January 2019	37		ACR, AAFP	CPT Assist	Codes Rep	October 20	XXX	0.84	2.31	NA	0.06	1976	TRUE	July 2014	Yes	FALSE					TRUE	Maintain
70373	Laryngography	Laryngography	October 2012			ACR, AAFP	CPT Assist	Codes Rep	October 2012							TRUE	July 2014	Yes	FALSE					TRUE	Maintain
70450	Computed tom	CT Head/Brain	April 2019	15		ACR, ASNR	0.85	CMS-Othe	April 2011	XXX	0.85	2.43	NA	0.05	5711912	FALSE			FALSE					TRUE	Maintain
70460	Computed tom	CT Head/Brain	April 2019	15		ACR, ASNR	1.13	CMS High	April 2013	XXX	1.13	3.49	NA	0.06	28050	FALSE			FALSE					TRUE	Maintain
70470	Computed tom	CT Head/Brain	April 2019	15		ACR, ASNR	1.27	Harvard V	October 20	XXX	1.27	4.17	NA	0.06	92135	FALSE			FALSE					TRUE	Maintain
70480	Computed tom	CT – Orbit/Ear/Fossa	October 2018	16		ACR, ASNR	1.28	CMS-Othe	October 20	XXX	1.28	3.64	NA	0.06	54791	FALSE			FALSE					TRUE	Maintain
70481	Computed tom	CT – Orbit/Ear/Fossa	October 2018	16		ACR, ASNR	1.13	CMS-Othe	October 20	XXX	1.13	4.56	NA	0.06	10929	FALSE			FALSE					TRUE	Decrease
70482	Computed tom	CT – Orbit/Ear/Fossa	October 2018	16		ACR, ASNR	1.27	CMS-Othe	October 20	XXX	1.27	5.42	NA	0.07	4917	FALSE			FALSE					TRUE	Decrease
70486	Computed tom	CT – Maxillofacial	April 2014	41		ACR, ASNR	0.85	CMS-Othe	April 2013	XXX	0.85	3.13	NA	0.05	532110	FALSE			FALSE					TRUE	Decrease
70487	Computed tom	CT – Maxillofacial	April 2014	41		ACR, ASNR	1.17	CMS-Othe	April 2014	XXX	1.13	3.62	NA	0.06	30559	FALSE			FALSE					TRUE	Decrease
70488	Computed tom	CT – Maxillofacial	April 2014	41		ACR, ASNR	1.30	CMS-Othe	April 2014	XXX	1.27	4.56	NA	0.06	3505	FALSE			FALSE					TRUE	Decrease
70490	Computed tom	CT Soft Tissue Neck	January 2017	21		ACR, ASNR	1.28	CMS High	July 2015	XXX	1.28	3.38	NA	0.06	68230	FALSE			FALSE					TRUE	Maintain
70491	Computed tom	CT Soft Tissue Neck	January 2017	21		ACR, ASNR	1.38	CMS High	July 2015	XXX	1.38	4.41	NA	0.06	279888	FALSE			FALSE					TRUE	Maintain
70492	Computed tom	CT Soft Tissue Neck	January 2017	21		ACR, ASNR	1.62	CMS High	July 2015	XXX	1.62	5.37	NA	0.10	25867	FALSE			FALSE					TRUE	Increase
70496	Computed tom	CT Angiography – He	January 2019	37		ACR, ASNR	1.75	High Volum	February 2	XXX	1.75	6.80	NA	0.11	525192	FALSE			FALSE					TRUE	Maintain
70498	Computed tom	CT Angiography – He	January 2019	37		ACR, ASNR	1.75	High Volum	February 2	XXX	1.75	6.79	NA	0.11	546880	FALSE			FALSE					TRUE	Maintain
70540	Magnetic reso	MRI Face and Neck	January 2016	39		ACR, ASNR	1.35	CMS High	July 2015	XXX	1.35	6.02	NA	0.07	10325	FALSE			FALSE					TRUE	Maintain
70542	Magnetic reso	MRI Face and Neck	January 2016	39		ACR, ASNR	1.62	CMS High	July 2015	XXX	1.62	7.14	NA	0.11	993	FALSE			FALSE					TRUE	Maintain
70543	Magnetic reso	MRI Face and Neck	January 2016	39		ACR, ASNR	2.15	CMS High	July 2015	XXX	2.15	8.88	NA	0.12	61843	FALSE			FALSE					TRUE	Maintain
70544	Magnetic reso	Magnetic Resonance	October 2016	18	RUC	ACR, ASNR	1.20	CMS High	July 2015	XXX	1.2	5.71	NA	0.07	247119	FALSE			FALSE					TRUE	Maintain
70545	Magnetic reso	Magnetic Resonance	October 2016	18	RUC	ACR, ASNR	1.20	CMS High	July 2015	XXX	1.2	6.08	NA	0.07	3638	FALSE			FALSE					TRUE	Maintain
70546	Magnetic reso	Magnetic Resonance	October 2016	18	RUC	ACR, ASNR	1.48	CMS High	July 2015	XXX	1.48	9.09	NA	0.10	18220	FALSE			FALSE					TRUE	Decrease
70547	Magnetic reso	Magnetic Resonance	October 2016	19	RUC	ACR, ASNR	1.20	CMS High	July 2015	XXX	1.2	5.74	NA	0.07	78876	FALSE			FALSE					TRUE	Maintain
70548	Magnetic reso	Magnetic Resonance	October 2016	19	RUC	ACR, ASNR	1.50	CMS High	July 2015	XXX	1.5	6.32	NA	0.08	17524	FALSE			FALSE					TRUE	Increase
70549	Magnetic reso	Magnetic Resonance	October 2016	19	RUC	ACR, ASNR	1.80	CMS High	July 2015	XXX	1.8	9.27	NA	0.13	58959	FALSE			FALSE					TRUE	Maintain
70551	Magnetic reso	MRI-Brain	January 2013	26		ACR, ASNR	1.48	CMS High	Septembe	XXX	1.48	4.76	NA	0.08	1166152	FALSE			FALSE					TRUE	Maintain
70552	Magnetic reso	MRI-Brain	January 2013	26		ACR, ASNR	1.78	CMS High	Septembe	XXX	1.78	6.91	NA	0.11	21951	FALSE			FALSE					TRUE	Maintain
70553	Magnetic reso	MRI-Brain	January 2013	26		ACR, ASNR	2.36	CMS-Othe	April 2011	XXX	2.29	7.97	NA	0.13	1005264	FALSE			FALSE					TRUE	Maintain
71010	Radiologic exa	Chest X-Rays	April 2016	07		ACR	Deleted fr	Low Value	October 2010							FALSE			FALSE		February 2	20	Complete	TRUE	Deleted from CPT
71015	Radiologic exa	Chest X-Rays	April 2016	07		ACR	Deleted fr	CMS High	July 2015							FALSE			FALSE		February 2	20	Complete	TRUE	Deleted from CPT
71020	Radiologic exa	Chest X-Rays	April 2016	07		ACR	Deleted fr	MPC List /	October 2010							FALSE			FALSE		February 2	20	Complete	TRUE	Deleted from CPT
71021	Radiologic exa	Chest X-Rays	April 2016	07		ACR	Deleted fr	CMS High	July 2015							FALSE			FALSE		February 2	20	Complete	TRUE	Deleted from CPT
71022	Radiologic exa	Chest X-Rays	April 2016	07		ACR	Deleted fr	CMS High	July 2015							FALSE			FALSE		February 2	20	Complete	TRUE	Deleted from CPT

71023	Radiologic exa	Chest X-Ray	April 2016	07		ACR	Deleted fr	CMS High	July 2015							FALSE			FALSE		February 2	20	Complete	TRUE	Deleted from CPT
71030	Radiologic exa	Chest X-Rays	April 2016	07		ACR	Deleted fr	CMS High	July 2015							FALSE			FALSE		February 2	20	Complete	TRUE	Deleted from CPT
71034	Radiologic exa	Chest X-Rays	April 2016	07		ACR	Deleted fr	CMS High	July 2015							FALSE			FALSE		February 2	20	Complete	TRUE	Deleted from CPT
71035	Radiologic exa	Chest X-Rays	April 2016	07		ACR	Deleted fr	CMS High	July 2015							FALSE			FALSE		February 2	20	Complete	TRUE	Deleted from CPT
71045	Radiologic exa	Chest X-Ray	April 2016	07		ACR	0.18	CMS High	February 2	XXX	0.18	0.55	NA	0.02	15582853	FALSE			FALSE		February 2	20	Complete	TRUE	Decrease
71046	Radiologic exa	Chest X-Ray	April 2016	07		ACR	0.22	CMS High	February 2	XXX	0.22	0.74	NA	0.02	10465557	FALSE			FALSE		February 2	20	Complete	TRUE	Decrease
71047	Radiologic exa	Chest X-Ray	April 2016	07		ACR	0.27	CMS High	February 2	XXX	0.27	0.95	NA	0.02	15324	FALSE			FALSE		February 2	20	Complete	TRUE	Decrease
71048	Radiologic exa	Chest X-Ray	April 2016	07		ACR	0.31	CMS High	February 2	XXX	0.31	1.00	NA	0.02	10897	FALSE			FALSE		February 2	20	Complete	TRUE	Decrease
71090	Insertion pace	Insertion/Removal o	April 2011	10		ACC	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	33213 - This code, when (	February 2	13	Complete	TRUE	Deleted from CPT
71100	Radiologic exa	X-Ray of Ribs	April 2016	30		ACR	0.22	CMS-Othe	April 2013	XXX	0.22	0.83	NA	0.02	174554	FALSE			FALSE					TRUE	Maintain
71101	Radiologic exa	X-Ray of Ribs	April 2016	30		ACR	0.27	CMS-Othe	October 2(	XXX	0.27	0.94	NA	0.02	301474	FALSE			FALSE					TRUE	Maintain
71110	Radiologic exa	X-Ray of Ribs	April 2016	30		ACR	0.29	CMS-Othe	October 2(	XXX	0.29	0.97	NA	0.02	24795	FALSE			FALSE					TRUE	Maintain
71111	Radiologic exa	X-Ray of Ribs	April 2016	30		ACR	0.32	CMS-Othe	October 2(	XXX	0.32	1.19	NA	0.02	30595	FALSE			FALSE					TRUE	Maintain
71250	Computed tom	Screening CT of Tho	October 2019	07		ACR	1.16	CMS Faste	October 2(	XXX	1.08	3.04	NA	0.06	2320224	FALSE			FALSE					TRUE	Increase
71260	Computed tom	Screening CT of Tho	October 2019	07		ACR	1.38	CMS High	July 2015	XXX	1.16	4.07	NA	0.06	1835534	FALSE			FALSE					TRUE	Maintain
71270	Computed tom	Screening CT of Tho	October 2019	07		ACR	1.24	CMS High	July 2015	XXX	1.25	4.96	NA	0.06	70977	FALSE			FALSE					TRUE	Maintain
71271	Computed tom	Screening CT of Tho	October 2019	07			1.16	CMS-Othe	May 2019	XXX	1.08	3.18	NA	0.06		FALSE			FALSE					TRUE	Increase
71275	Computed tom	CT Angiography-Che	January 2014	27		ACR, SIR	1.82	CMS Faste	October 2(	XXX	1.82	6.91	NA	0.11	1282747	TRUE	Jun 2009	Yes	FALSE					TRUE	Decrease
72020	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.16	CMS-Othe	April 2016	XXX	0.16	0.54	NA	0.02	145820	FALSE			FALSE					TRUE	Increase
72040	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.22	Low Value	October 2(	XXX	0.22	0.91	NA	0.02	641468	FALSE			TRUE	The RUC recommended c	October 2(	17	Complete	TRUE	Maintain
72050	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.27	Low Value	October 2(	XXX	0.27	1.25	NA	0.02	378821	FALSE			TRUE	The RUC recommended c	October 2(	17	Complete	TRUE	Decrease
72052	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.30	Low Value	October 2(	XXX	0.3	1.49	NA	0.02	80862	FALSE			TRUE	The RUC recommended c	October 2(	17	Complete	TRUE	Decrease
72070	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.20	CMS-Othe	April 2013	XXX	0.2	0.73	NA	0.02	300255	FALSE			FALSE					TRUE	Decrease
72072	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.23	CMS-Othe	April 2016	XXX	0.23	0.89	NA	0.02	184802	FALSE			FALSE					TRUE	Increase
72074	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.25	CMS-Othe	October 2(	XXX	0.25	1.03	NA	0.02	12934	FALSE			FALSE					TRUE	Increase
72080	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.21	CMS-Othe	October 2(	XXX	0.21	0.78	NA	0.02	46745	FALSE			FALSE					TRUE	Decrease
72100	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.22	Harvard V:	February 2	XXX	0.22	0.92	NA	0.02	1818987	FALSE			TRUE	This service was brought	October 2(	18	Complete	TRUE	Maintain
72110	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.26	Harvard V:	October 2(	XXX	0.26	1.20	NA	0.02	821121	FALSE			TRUE	April 2010, refer to CPT E	October 2(	18	Complete	TRUE	Decrease
72114	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.30	Harvard V:	February 2	XXX	0.3	1.49	NA	0.02	96261	FALSE			TRUE	This service was brought	October 2(	18	Complete	TRUE	Decrease
72120	Radiologic exa	X-Ray Spine	January 2019	27		AAOS, ACF	0.22	Harvard V:	February 2	XXX	0.22	0.95	NA	0.02	52798	FALSE			TRUE	Code 72110 was identifie	October 2(	18	Complete	TRUE	Maintain
72125	Computed tom	CT Spine	April 2018	18		ACR, ASNF	1.07	CMS Faste	October 2(	XXX	1	3.04	NA	0.06	1308607	FALSE			FALSE					TRUE	Maintain
72126	Computed tom	CT Spine	April 2018	18		ACR, ASNF	1.22	CMS Faste	February 2	XXX	1.22	4.06	NA	0.06	20553	FALSE			FALSE					TRUE	Maintain
72127	Computed tom	CT Spine	April 2018	18		ACR, ASNF	1.27	CMS Faste	February 2	XXX	1.27	4.94	NA	0.06	1798	FALSE			FALSE					TRUE	Maintain
72128	Computed tom	CT Spine	April 2018	18		ACR, ASNF	1.00	CMS Faste	October 2(	XXX	1	3.03	NA	0.06	199533	FALSE			FALSE					TRUE	Maintain
72129	Computed tom	CT Spine	April 2018	18		ACR, ASNF	1.22	CMS Faste	February 2	XXX	1.22	4.09	NA	0.06	26437	FALSE			FALSE					TRUE	Maintain
72130	Computed tom	CT Spine	April 2018	18		ACR, ASNF	1.27	CMS Faste	February 2	XXX	1.27	4.97	NA	0.06	1318	FALSE			FALSE					TRUE	Maintain
72131	Computed tom	CT Spine	April 2018	18		ACR, ASNF	1.00	CMS Faste	February 2	XXX	1	3.02	NA	0.06	519043	FALSE			FALSE					TRUE	Maintain
72132	Computed tom	CT Spine	April 2018	18		ACR, ASNF	1.22	CMS Faste	February 2	XXX	1.22	4.06	NA	0.06	61654	FALSE			FALSE					TRUE	Maintain
72133	Computed tom	CT Spine	April 2018	18		ACR, ASNF	1.27	CMS Faste	February 2	XXX	1.27	4.94	NA	0.06	4078	FALSE			FALSE					TRUE	Maintain
72141	Magnetic reso	MRI Neck and Lumb	April 2013	25		ACR	1.48	CMS High	Septembe	XXX	1.48	4.63	NA	0.07	600156	FALSE			FALSE					TRUE	Decrease
72142	Magnetic reso	MRI Neck and Lumb	April 2013	25		ACR	1.78	CMS High	April 2013	XXX	1.78	7.12	NA	0.11	3391	FALSE			FALSE					TRUE	Decrease
72146	Magnetic reso	MRI Neck and Lumb	April 2013	25		ACR	1.48	CMS High	April 2013	XXX	1.48	4.63	NA	0.07	223500	FALSE			FALSE					TRUE	Decrease
72147	Magnetic reso	MRI Neck and Lumb	April 2013	25		ACR	1.78	CMS High	April 2013	XXX	1.78	7.06	NA	0.11	3124	FALSE			FALSE					TRUE	Decrease
72148	Magnetic reso	MRI Neck and Lumb	April 2013	25		AAOS, AUI	1.48	CMS-Othe	April 2011	XXX	1.48	4.64	NA	0.07	1346832	FALSE			FALSE					TRUE	Maintain
72149	Magnetic reso	MRI Neck and Lumb	April 2013	25			1.78	CMS High	April 2013	XXX	1.78	6.98	NA	0.11	5622	FALSE			FALSE					TRUE	Maintain
72156	Magnetic reso	MRI Neck and Lumb	April 2013	25			2.29	CMS High	April 2013	XXX	2.29	8.07	NA	0.13	120879	FALSE			FALSE					TRUE	Decrease
72157	Magnetic reso	MRI Neck and Lumb	April 2013	25			2.29	CMS High	April 2013	XXX	2.29	8.09	NA	0.13	98889	FALSE			FALSE					TRUE	Decrease
72158	Magnetic reso	MRI Neck and Lumb	April 2013	25			2.29	CMS High	April 2013	XXX	2.29	8.05	NA	0.13	244364	FALSE			FALSE					TRUE	Decrease
72170	Radiologic exa	X-Ray Exam – Pelvis	January 2019	28		AAOS, ACF	0.17	Low Value	October 2(	XXX	0.17	0.62	NA	0.02	792294	FALSE			TRUE	The Joint Workgroup reco	October 2(	27	Complete	TRUE	Maintain
72190	Radiologic exa	X-Ray Exam – Pelvis	January 2019	28		AAOS, ACF	0.25	CMS-Othe	October 2(	XXX	0.25	0.95	NA	0.02	56338	FALSE			FALSE					TRUE	Increase
72191	Computed tom	CT Angiography	October 2013	12		ACR, SIR	1.81	High Volur	February 2	XXX	1.81	7.69	NA	0.11	2441	FALSE			TRUE	The Workgroup accepts t	October 2(	19	Complete	TRUE	Maintain
72192	Computed tom	CT Pelvis	October 2008	26		ACR	1.09	Codes Rep	October 2(	XXX	1.09	3.04	NA	0.06	183953	FALSE			TRUE	The specialty society indi	October 2(	37	Complete	TRUE	Maintain
72193	Computed tom	CT Pelvis	October 2008	26		ACR	1.16	Codes Rep	October 2(	XXX	1.16	6.05	NA	0.06	37206	FALSE			TRUE	The specialty society indi	October 2(	37	Complete	TRUE	Maintain
72194	Computed tom	CT Abdomen and Pe	April 2014	44		ACR	1.22	Codes Rep	February 2	XXX	1.22	6.81	NA	0.07	5552	FALSE			TRUE	Referred to the CPT Edito	October 2(	37	Complete	TRUE	Maintain
72195	Magnetic reso	MRI Pelvis	October 2016	21	RUC	ACR	1.46	CMS High	July 2015	XXX	1.46	6.02	NA	0.08	85947	FALSE			FALSE					TRUE	Maintain
72196	Magnetic reso	MRI Pelvis	October 2016	21	RUC	ACR	1.73	CMS High	July 2015	XXX	1.73	7.04	NA	0.11	2606	FALSE			FALSE					TRUE	Maintain
72197	Magnetic reso	MRI Pelvis	October 2016	21	RUC	ACR	2.20	CMS High	July 2015	XXX	2.2	8.83	NA	0.12	214192	FALSE			FALSE					TRUE	Decrease
72200	Radiologic exa	X-Ray Sacrum	January 2019	29		AAOS, ACF	0.20	CMS-Othe	October 2(	XXX	0.17	0.77	NA	0.02	14605	FALSE			FALSE					TRUE	Increase
72202	Radiologic exa	X-Ray Sacrum	January 2019	29		AAOS, ACF	0.26	CMS-Othe	October 2(	XXX	0.23	0.89	NA	0.02	39418	FALSE			FALSE					TRUE	Increase
72220	Radiologic exa	X-Ray Sacrum	January 2019	29		AAOS, ACF	0.20	CMS-Othe	April 2016	XXX	0.17	0.75	NA	0.02	116528	FALSE			FALSE					TRUE	Increase
72240	Myelography,	Myelography	April 2014	17		ACR, ASNF	0.91	Codes Rep	October 2(	XXX	0.91	2.43	NA	0.06	647	FALSE			TRUE	Joint Workgroup request:	October 2(	21	Complete	TRUE	Maintain
72255	Myelography,	Myelography	April 2014	17		ACR, ASNF	0.91	Codes Rep	October 2(	XXX	0.91	2.43	NA	0.11	125	FALSE			TRUE	This code change applicat	October 2(	21	Complete	TRUE	Maintain
72265	Myelography,	Myelography	April 2014	17		ACR, ASNF	0.83	Codes Rep	October 2(	XXX	0.83	2.29	NA	0.05	3681	FALSE			TRUE	Joint Workgroup request:	October 2(	21	Complete	TRUE	Maintain
72270	Myelography,	Myelography	April 2014	17		ACR, ASNF	1.33	Codes Rep	October 2(	XXX	1.33	2.94	NA	0.07	1087	FALSE			TRUE	Joint Workgroup request:	October 2(	21	Complete	TRUE	Maintain
72275	Epidurography	Epidurography	January 2020	37		ASA, AAPN	Deleted fr	Different F	October 2(	XXX	0.76	3.29	NA	0.05	66516	TRUE	Oct 2009 a	Yes	TRUE	In October 2019, this serv	October 2(	40	complete	TRUE	Deleted from CPT
72291	Radiological su	Percutaneous Vertel	April 2014	06			Deleted fr	Codes Rep	October 2012							FALSE			TRUE	Joint Workgroup recomm	February 2	16	Complete	TRUE	Deleted from CPT
72292	Radiological su	Percutaneous Vertel	April 2014	06			Deleted fr	Codes Rep	October 2012							FALSE			TRUE	Joint Workgroup recomm	February 2	16	Complete	TRUE	Deleted from CPT
73000	Radiologic exa	X-Ray – Clavicle/Sho	October 2018	17		ACR, AAOS	0.16	CMS-Othe	October 2(	XXX	0.16	0.76	NA	0.02	100682	FALSE			FALSE					TRUE	Maintain
73010	Radiologic exa	X-Ray – Clavicle/Sho	October 2018	17		ACR, AAOS	0.17	CMS-Othe	October 2(	XXX	0.17	0.50	NA	0.02	51052	FALSE			FALSE					TRUE	Maintain
73020	Radiologic exa	X-Ray – Clavicle/Sho	October 2018	17		ACR, AAOS	0.15	CMS-Othe	October 2(	XXX	0.15	0.46	NA	0.02	119144	FALSE			FALSE					TRUE	Maintain
73030	Radiologic exa	X-Ray – Clavicle/Sho	October 2018	17		ACR, AAOS	0.18	Low Value	October 2(	XXX	0.18	0.80	NA	0.02	2765924	FALSE			FALSE					TRUE	Maintain
73050	Radiologic exa	X-Ray – Clavicle/Sho	October 2018	17		ACR, AAOS	0.18	CMS-Othe	October 2(	XXX	0.18	0.63	NA	0.02	8123	FALSE			FALSE					TRUE	Decrease
73060	Radiologic exa	X-Ray Exams	September 201	17		AAOS, ACF	0.16	CMS-Othe	April 2013	XXX	0.16	0.76	NA	0.02	341436	FALSE			FALSE					TRUE	Decrease
73070	Radiologic exa	X-Ray Elbow/Forear	January 2019	30		AAOS, ACF	0.16	CMS-Othe	April 2016	XXX	0.16	0.67	NA	0.02	219794	FALSE			FALSE					TRUE	Increase
73080	Radiologic exa	X-Ray Elbow/Forear	January 2019	30		AAOS, ACF	0.17	Harvard V:	October 2(	XXX	0.17	0.75	NA	0.02	404093	FALSE			FALSE					TRUE	Maintain
73090	Radiologic exa	X-Ray Elbow/Forear	January 2019	30		AAOS, ACF	0.16	CMS-Othe	April 2016	XXX	0.16	0.67	NA	0.02	230897	FALSE			FALSE					TRUE	Maintain
73100	Radiologic exa	X-Ray Wrist	April 2016	32		ACR	0.16	CMS High	July 2015	XXX	0.16	0.81	NA	0.02	274134	FALSE			FALSE					TRUE	Maintain
73110	Radiologic exa	X-Ray Wrist	April 2016	32		ACR	0.17	Low Value	October 2(	XXX	0.17	0.99	NA	0.02	1064258	FALSE			FALSE					TRUE	Maintain
73120	Radiologic exa	X-Ray of Hand/Finge	April 2016	33		ACR	0.16	CMS High	July 2015	XXX	0.16	0.73	NA	0.02	278753	FALSE			FALSE					TRUE	Maintain
73130	Radiologic exa	X-Ray of Hand/Finge	April 2016	33		ACR	0.17	Low Value	October 2(	XXX	0.17	0.87	NA	0.02	1282863	FALSE			FALSE					TRUE	Maintain

73140	Radiologic exa	X-Ray of Hand/Finge	April 2016	33		ACR	0.13	CMS High	July 2015	XXX	0.13	0.94	NA	0.02	388288	FALSE			FALSE							TRUE	Maintain
73200	Computed ton	CT Upper Extremity	October 2009	23		ACR	1.09	CMS Faste	October 2(	XXX	1	4.14	NA	0.06	126320	FALSE			FALSE							TRUE	Maintain
73201	Computed ton	CT Upper Extremity	October 2009	40		ACR	Remove fr	CMS Faste	February 2	XXX	1.16	5.25	NA	0.06	21360	FALSE			FALSE							TRUE	Remove from Screen
73202	Computed ton	CT Upper Extremity	October 2009	40		ACR	Remove fr	CMS Faste	February 2	XXX	1.22	6.80	NA	0.07	1982	FALSE			FALSE							TRUE	Remove from Screen
73206	Computed ton	CT Angiography	October 2013	12		ACR, SIR	Survey wit	CMS Requ	May 2013	XXX	1.81	7.60	NA	0.13	6543	FALSE			FALSE							TRUE	Remove from Screen
73218	Magnetic reso	MRI	October 2013	18		ACR	CPT Assist	CMS Faste	October 2(	XXX	1.35	8.72	NA	0.07	33624	TRUE	Feb 2011	Yes	FALSE							TRUE	Maintain
73221	Magnetic reso	MRI	January 2012	20		ACR	1.35	CMS Faste	October 2(	XXX	1.35	5.13	NA	0.08	475051	FALSE			FALSE							TRUE	Maintain
73500	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	Deleted fr	CMS-Othe	April 2011							FALSE			TRUE	In Jan 2012, the specialty		October 2(	27	Complete		TRUE	Deleted from CPT
73501	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	0.17	Codes Rep	October 2(	XXX	0.18	0.74	NA	0.02	285022	FALSE			FALSE			October 2(	27	Complete		TRUE	Decrease
73502	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	0.22	Codes Rep	October 2(	XXX	0.22	1.12	NA	0.02	2694536	FALSE			FALSE			October 2(	27	Complete		TRUE	Decrease
73503	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	0.27	Codes Rep	October 2(	XXX	0.27	1.42	NA	0.02	46804	FALSE			FALSE			October 2(	27	Complete		TRUE	Decrease
73510	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	Deleted fr	Havard Va	October 2008							FALSE			FALSE			October 2(	27	Complete		TRUE	Deleted from CPT
73520	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	Deleted fr	CMS-Othe	April 2013							FALSE			TRUE	CPT code 73520 was iden		October 2(	27	Complete		TRUE	Deleted from CPT
73521	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	0.22	Codes Rep	October 2(	XXX	0.22	0.96	NA	0.02	158149	FALSE			FALSE			October 2(	27	Complete		TRUE	Decrease
73522	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	0.29	Codes Rep	October 2(	XXX	0.29	1.25	NA	0.02	188143	FALSE			FALSE			October 2(	27	Complete		TRUE	Decrease
73523	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	0.31	Codes Rep	October 2(	XXX	0.31	1.46	NA	0.02	107476	FALSE			FALSE			October 2(	27	Complete		TRUE	Decrease
73540	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	Deleted fr	Codes Rep	October 2014							FALSE			FALSE			October 2(	27	Complete		TRUE	Deleted from CPT
73542	Radiological e	Sacroiliac Joint Arth	April 2010	45		ASA, AAPM	Deleted fr	Different F	October 2009							TRUE	Deleted fr	Yes	TRUE	The RUC recommends rel		February 2	76	Code Delete		TRUE	Deleted from CPT
73550	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	Deleted fr	CMS-Othe	April 2011							FALSE			TRUE	In Jan 2012, the specialty		October 2(	27	Complete		TRUE	Deleted from CPT
73551	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	0.16	Codes Rep	October 2(	XXX	0.16	0.68	NA	0.02	37871	FALSE			FALSE			October 2(	27	Complete		TRUE	Decrease
73552	Radiologic exa	Radiologic Exam-Hip	April 2015	14		AAOS, ACF	0.18	Codes Rep	October 2(	XXX	0.18	0.83	NA	0.02	548327	FALSE			FALSE			October 2(	27	Complete		TRUE	Decrease
73560	Radiologic exa	X-Ray Exams	September 201	17		AAOS, ACF	0.16	Low Value	October 2(	XXX	0.16	0.82	NA	0.02	1784814	FALSE			FALSE							TRUE	Decrease
73562	Radiologic exa	X-Ray Exams	September 201	17		AAOS, ACF	0.18	Low Value	October 2(	XXX	0.18	0.98	NA	0.02	2516006	FALSE			FALSE							TRUE	Maintain
73564	Radiologic exa	X-Ray Exams	September 201	17		AAOS, ACF	0.22	Low Value	October 2(	XXX	0.22	1.10	NA	0.02	1648754	FALSE			FALSE							TRUE	Maintain
73565	Radiologic exa	X-Ray Exams	September 201	17		AAOS, ACF	0.16	CMS-Othe	April 2013	XXX	0.16	1.01	NA	0.02	207121	FALSE			FALSE							TRUE	Decrease
73580	Radiologic exa	Contrast X-Ray of Kn	October 2021	16		ACR	0.59	High Volur	February 2	XXX	0.54	3.68	NA	0.06	30453	TRUE	Jun 2012	Yes	FALSE							TRUE	Increase
73590	Radiologic exa	X-Ray Exams	September 201	17		AAOS, ACF	0.16	CMS-Othe	April 2013	XXX	0.16	0.74	NA	0.02	500593	FALSE			FALSE							TRUE	Decrease
73600	Radiologic exa	X-Ray Exams	September 201	17		AAOS, ACF	0.16	CMS-Othe	April 2013	XXX	0.16	0.77	NA	0.02	240693	FALSE			FALSE							TRUE	Maintain
73610	Radiologic exa	Radiologic Examinat	October 2009	24		ACR, AAOS	0.17	Havard Va	October 2(	XXX	0.17	0.88	NA	0.02	1281503	FALSE			FALSE							TRUE	Maintain
73620	Radiologic exa	X-Ray Exam of Foot	April 2011	27		ACR, AAOS	0.16	Low Value	October 2(	XXX	0.16	0.65	NA	0.02	574129	FALSE			FALSE							TRUE	Maintain
73630	Radiologic exa	Radiologic Examinat	October 2009	24		ACR, AAOS	0.17	Havard Va	October 2(	XXX	0.17	0.81	NA	0.02	2820181	FALSE			FALSE							TRUE	Maintain
73650	Radiologic exa	X-Ray Heel	January 2019	31		AAOS, ACF	0.16	CMS-Othe	April 2016	XXX	0.16	0.66	NA	0.02	81836	FALSE			FALSE							TRUE	Maintain
73660	Radiologic exa	X-Ray Toe	January 2019	32		AAOS, ACF	0.13	CMS-Othe	April 2016	XXX	0.13	0.70	NA	0.02	120091	FALSE			FALSE							TRUE	Maintain
73700	Computed ton	CT Lower Extremity	April 2018	21		ACR	1.00	CMS Faste	October 2(	XXX	1	3.02	NA	0.06	338278	FALSE			FALSE							TRUE	Maintain
73701	Computed ton	CT Lower Extremity	April 2018	21		ACR	1.16	High Volur	February 2	XXX	1.16	4.06	NA	0.06	47637	FALSE			FALSE							TRUE	Maintain
73702	Computed ton	CT Lower Extremity	April 2018	21		ACR	1.22	High Volur	February 2	XXX	1.22	4.88	NA	0.06	4842	FALSE			FALSE							TRUE	Maintain
73706	Computed ton	CT Angiography	October 2013	12		ACR, SIR	Survey for	High Volur	February 2	XXX	1.9	8.30	NA	0.13	16508	FALSE			FALSE							TRUE	Remove from Screen
73718	Magnetic reso	MRI Lower Extremit	October 2016	20	RUC	ACR	1.35	CMS High	July 2015	XXX	1.35	5.93	NA	0.07	148143	FALSE			FALSE							TRUE	Maintain
73719	Magnetic reso	MRI Lower Extremit	October 2016	20	RUC	ACR	1.62	CMS High	July 2015	XXX	1.62	6.94	NA	0.11	1344	FALSE			FALSE							TRUE	Maintain
73720	Magnetic reso	MRI Lower Extremit	October 2016	20	RUC	ACR	2.15	CMS High	July 2015	XXX	2.15	8.88	NA	0.12	64864	FALSE			FALSE							TRUE	Maintain
73721	Magnetic reso	MRI of Lower Extren	January 2012	20		ACR	1.35	MPC List	October 2(	XXX	1.35	5.11	NA	0.08	670662	FALSE			FALSE							TRUE	Maintain
74000	Radiologic exa	Abdominal X-Ray	April 2016	08		ACR	Deleted fr	Low Value	October 2010							FALSE			FALSE			February 2	21	Complete		TRUE	Deleted from CPT
74010	Radiologic exa	Abdominal X-Ray	April 2016	08		ACR	Deleted fr	CMS High	July 2015							FALSE			FALSE			February 2	21	Complete		TRUE	Deleted from CPT
74018	Radiologic exa	Abdominal X-Ray	April 2016	08		ACR	0.18	CMS High	February 2	XXX	0.18	0.67	NA	0.02	2153087	FALSE			FALSE			February 2	21	Complete		TRUE	Decrease
74019	Radiologic exa	Abdominal X-Ray	April 2016	08		ACR	0.23	CMS High	February 2	XXX	0.23	0.83	NA	0.02	429437	FALSE			FALSE			February 2	21	Complete		TRUE	Decrease
74020	Radiologic exa	Abdominal X-Ray	April 2016	08		ACR	Deleted fr	CMS High	July 2015							FALSE			FALSE			February 2	21	Complete		TRUE	Deleted from CPT
74021	Radiologic exa	Abdominal X-Ray	April 2016	08		ACR	0.27	CMS High	February 2	XXX	0.27	0.96	NA	0.02	58811	FALSE			FALSE			February 2	21	Complete		TRUE	Decrease
74022	Radiologic exa	Abdominal X-Ray	April 2016	08		ACR	0.32	CMS High	July 2015	XXX	0.32	1.11	NA	0.02	283318	FALSE			FALSE			February 2	21	Complete		TRUE	Maintain
74150	Computed ton	CT Abdomen	February 2008	S		ACR	Review PE	Codes Rep	February 2	XXX	1.19	3.05	NA	0.06	77343	FALSE			TRUE	Referred to the CPT Edito		October 2(	37	Complete		TRUE	Maintain
74160	Computed ton	CT Abdomen and Pe	April 2014	44		ACR	0.42	Codes Rep	February 2	XXX	1.27	6.07	NA	0.06	105409	FALSE			TRUE	Referred to the CPT Edito		October 2(	37	Complete		TRUE	Maintain
74170	Computed ton	CT Abdomen	April 2012	34		ACR	1.40	Codes Rep	February 2	XXX	1.4	6.85	NA	0.08	107476	FALSE			TRUE	Referred to the CPT Edito		October 2(	37	Complete		TRUE	Maintain
74174	Computed ton	CT Angiography	October 2013	12		ACR, SIR	2.20	Codes Reported Toge		XXX	2.2	9.64	NA	0.15	294980	FALSE			FALSE							TRUE	Decrease
74175	Computed ton	CT Angiography	October 2013	12		ACR, SIR	1.82	CMS Faste	October 2(	XXX	1.82	7.68	NA	0.11	37638	FALSE			TRUE	The ACR submitted a lett		October 2(	19	Complete		TRUE	Decrease
74176	Computed ton	CT Abdomen/CT Pel	February 2010	16		ACR	1.74	CMS Faste	October 2(	XXX	1.74	3.91	NA	0.10	2284436	FALSE			FALSE			October 2(	37			TRUE	Decrease
74177	Computed ton	CT Abdomen and Pe	April 2014	44		ACR	1.82	CMS Faste	October 2(	XXX	1.82	7.79	NA	0.11	3361910	FALSE			FALSE			October 2(	37			TRUE	Decrease
74178	Computed ton	CT Abdomen/CT Pel	February 2010	16		ACR	2.01	CMS Faste	October 2(	XXX	2.01	8.78	NA	0.11	534971	FALSE			FALSE			October 2(	37			TRUE	Decrease
74181	Magnetic reso	MRI of Abdomen	October 2016	21	RUC	ACR	1.46	CMS High	July 2015	XXX	1.46	4.86	NA	0.07	117420	FALSE			FALSE							TRUE	Maintain
74182	Magnetic reso	MRI of Abdomen	October 2016	21	RUC	ACR	1.73	CMS High	July 2015	XXX	1.73	8.19	NA	0.11	4286	FALSE			FALSE							TRUE	Maintain
74183	Magnetic reso	MRI of Abdomen	October 2016	21	RUC	ACR	2.20	CMS High	July 2015	XXX	2.2	8.85	NA	0.12	354840	FALSE			FALSE							TRUE	Decrease
74210	Radiologic exa	X-Ray Exam – Upper	January 2019	12		ACR	0.59	CMS-Othe	October 2(	XXX	0.59	2.27	NA	0.05	1577	FALSE			FALSE							TRUE	Maintain
74220	Radiologic exa	X-Ray Exam – Upper	January 2019	12		ACR	0.60	CMS-Othe	April 2016	XXX	0.6	2.31	NA	0.05	196573	FALSE			FALSE							TRUE	Decrease
74221	Radiologic exa	X-Ray Exam – Upper	January 2019	12			0.70	CMS-Othe	October 2(	XXX	0.7	2.57	NA	0.05		FALSE			FALSE							TRUE	Increase
74230	Radiologic exa	X-Ray Esophagus	April 2017	25		ACR	0.53	CMS-Othe	April 2013	XXX	0.53	3.33	NA	0.05	370056	FALSE			FALSE							TRUE	Maintain
74240	Radiologic exa	X-Ray Exam – Upper	January 2019	12		ACR	0.80	CMS-Othe	October 2(	XXX	0.8	2.82	NA	0.05	53309	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Increase
74241	Radiologic exa	X-Ray Exam – Upper	January 2019	12		ACR	Deleted fr	CMS-Othe	October 2017						25415	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Deleted from CPT
74245	Radiologic exa	X-Ray Exam – Upper	January 2019	12		ACR	Deleted fr	CMS-Othe	October 2017						12946	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Deleted from CPT
74246	Radiologic exa	X-Ray Exam – Upper	January 2019	12		ACR	0.90	CMS-Othe	October 2(	XXX	0.9	3.26	NA	0.05	34438	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Increase
74247	Radiological e	X-Ray Exam – Upper	January 2019	12		ACR	Deleted fr	Harvard Va	April 2011						21591	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Deleted from CPT
74248	Radiologic sm	X-Ray Exam – Upper	January 2019	12			0.70	CMS-Othe	October 2(	ZZZ	0.7	1.75	NA	0.04		FALSE			TRUE	In January 2019, the RUC		February 2	EC-T	Issue complete		TRUE	Increase
74249	Radiological e	X-Ray Exam – Upper	January 2019	12		ACR	Deleted fr	CMS-Othe	October 2017						13972	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Deleted from CPT
74250	Radiologic exa	Lower Gastroinetstir	October 2018	11		ACR	0.81	CMS-Othe	October 2(	XXX	0.81	2.82	NA	0.05	52021	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Increase
74251	Radiologic exa	Lower Gastroinetstir	October 2018	11		ACR	1.17	CMS-Othe	October 2(	XXX	1.17	10.69	NA	0.06	206	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Increase
74260	Duodenograpl	X-Ray Exam – Small	October 2018	11		ACR	Deleted fr	CMS-Othe	October 2017						24	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Deleted from CPT
74270	Radiologic exa	Lower Gastroinetstir	October 2018	11		ACR	1.04	CMS-Othe	October 2(	XXX	1.04	3.56	NA	0.06	28934	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Increase
74280	Radiologic exa	Lower Gastroinetstir	October 2018	11		ACR	1.26	Harvard Va	April 2011	XXX	1.26	5.41	NA	0.06	8205	FALSE			TRUE	In January 2018, the RUC		May 2018	27	Yes		TRUE	Increase
74300	Cholangiograp	X-Rays at Surgery Ac	April 2019	19		ACR, SAGE	0.32	CMS-Othe	October 2(	XXX	0	0.00	NA	0.00	29648	FALSE			FALSE							TRUE	Decrease
74301	Cholangiograp	X-Rays at Surgery Ac	October 2020	19		ACR, ACS,	0.21	CMS-Othe	October 2(	ZZZ	0	0.00	NA	0.00	63	FALSE			FALSE							TRUE	Maintain
74305	Deleted from (	Percutaneous Biliary	October 2015	06	RUC	ACR, SIR	Deleted fr	Codes Rep	October 2012							FALSE			TRUE	The Joint Workgroup rec		February 2	16	Complete		TRUE	Deleted from CPT
74320	Cholangiograp	Percutaneous Biliary	October 2015	06	RUC	ACR, SIR	Deleted fr	Codes Rep	October 2012							FALSE			TRUE	The Joint Workgroup rec		February 2	16	Complete		TRUE	Deleted from CPT
74327	Postoperative	Percutaneous Biliary	October 2015	06	RUC	ACR, SIR	Deleted fr	Codes Rep	February 2015							FALSE			FALSE			February 2	16			TRUE	Deleted from CPT

74328	Endoscopic cat	X-Rays at Surgery Ac	April 2019	19			ACR, SAGE	0.47	CMS-Othe	October 2(	XXX	0	0.00	NA	0.00	64506	FALSE			FALSE						TRUE	Decrease
74329	Endoscopic cat	X-Rays at Surgery Ac	April 2019	19			ACR, SAGE	0.50	CMS-Othe	October 2(	XXX	0	0.00	NA	0.00	2990	FALSE			FALSE						TRUE	Decrease
74330	Combined end	X-Rays at Surgery Ac	April 2019	19			ACR, SAGE	0.70	CMS-Othe	October 2(	XXX	0	0.00	NA	0.00	13859	FALSE			FALSE						TRUE	Decrease
74400	Urography (py	Contrast X-Ray Exan	September 201	31			ACR	0.49	Harvard V:	April 2011	XXX	0.49	3.46	NA	0.03	5180	FALSE			FALSE						TRUE	Maintain
74420	Urography, ret	X-Ray Urinary Tract	April 2017	26			ACR, AUA	0.52	CMS-Othe	April 2016	XXX	0.52	1.69	NA	0.03	166220	FALSE			FALSE						TRUE	Increase
74425	Urography, an	Urography	October 2018	18			ACR, AUA,	0.51, edit	Codes Rep	October 2(	XXX	0.51	3.53	NA	0.03	3703	FALSE			TRUE	CPT code 74425 was bun	Septembe 27		yes		TRUE	Increase
74475	Introduction o	Genitourinary Cathe	January 2015	09			ACR, SIR	Deleted fr	Codes Rep	October 2012							FALSE			TRUE	The Joint Workgroup rec	October 2(	18	Complete		TRUE	Deleted from CPT
74480	Introduction o	Genitourinary Cathe	January 2015	09			ACR, SIR	Deleted fr	Codes Rep	October 2012							FALSE			TRUE	The Joint Workgroup rec	October 2(	18	Complete		TRUE	Deleted from CPT
74485	Dilation of ure	Dilation of Urinary T	January 2018	12				0.83	Codes Rep	Septembe	XXX	0.83	2.63	NA	0.03	1628	FALSE			FALSE						TRUE	Increase
75561	Cardiac magnetic resonance imagir		January 2021	29				Maintain	High Volur	October 2(	XXX	2.6	9.39	NA	0.13	29956	FALSE			FALSE						TRUE	Remove from screen
75572	Computed tomography, heart, with		January 2021	29				Maintain	High Volur	October 2(	XXX	1.75	6.13	NA	0.08	29288	FALSE			FALSE						TRUE	Remove from screen
75574	Computed tomographic angiograph		January 2021	29			ACR, SIR, A	Maintain	CMS Requ	May 2013	XXX	2.4	9.10	NA	0.14	86531	FALSE			FALSE						TRUE	Remove from screen
75625	Aortography, a	Abdominal Aortogra	October 2018	19			ACC, SCAI,	1.75	CMS-Othe	October 2(	XXX	1.44	2.29	NA	0.20	96916	FALSE			FALSE						TRUE	Increase
75630	Aortography, a	Abdominal Aortogra	October 2018	19			ACC, SCAI,	2.00	CMS-Othe	October 2(	XXX	2	2.62	NA	0.22	27465	FALSE			FALSE						TRUE	Increase
75635	Computed ton	CT Angiography of A	April 2016	34			ACR	2.40	High Volur	February 2	XXX	2.4	10.42	NA	0.17	114472	FALSE			FALSE						TRUE	Maintain
75650	Angiography, c	Carotid Angiography	April 2010	45			ACC, ACR,	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The Workgroup recomme	February 2	12	Complete		TRUE	Deleted from CPT
75671	Angiography, c	Carotid Angiography	April 2010	45			AANS/CNS	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The Workgroup recomme	February 2	12	Complete		TRUE	Deleted from CPT
75680	Angiography, c	Carotid Angiography	April 2010	45			AANS/CNS	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The Workgroup recomme	February 2	12	Complete		TRUE	Deleted from CPT
75710	Angiography, e	Angiography of Extr	January 2021	29	January 2(	RAW	ACR, ACC,	Refer to CI	CMS High	July 2015	XXX	1.75	2.66	NA	0.23	157614	TRUE	July 2021	complete	FALSE						FALSE	Increase
75716	Angiography, e	Angiography of Extr	October 2016	22		RUC	ACR, ACC,	1.97	CMS High	July 2015	XXX	1.97	2.79	NA	0.23	74926	FALSE			FALSE						TRUE	Increase
75722	Angiography, r	Renal Angiography	April 2010	45			ACC, ACR,	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The Workgroup recomme	February 2	06	Code Delete		TRUE	Deleted from CPT
75724	Angiography, r	Renal Angiography	April 2010	45			ACC, ACR,	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The Workgroup recomme	February 2	06	Code Delete		TRUE	Deleted from CPT
75726	Angiography, \	Angiography	October 2018	20			SCAI, SIR, S	2.05	CMS-Othe	October 2(	XXX	2.05	3.00	NA	0.15	41396	FALSE			FALSE						TRUE	Increase
75774	Angiography, s	Angiography	October 2018	20			SCAI, SIR, S	1.01	CMS-Othe	October 2(	ZZZ	1.01	1.93	NA	0.10	77363	FALSE			FALSE						TRUE	Increase
75790	Deleted from (	Arteriovenous Shun	April 2009	9			SVS, SIR, A	Deleted fr	Codes Rep	February 2008							FALSE			TRUE	Referred to the CPT Edito	February 2	31	Deleted		TRUE	Deleted from CPT
75791	Angiography, a	Dialysis Circuit -1	January 2016	14			ACR, RPA,	Deleted fr	Codes Reported Together 95% or More								FALSE			FALSE		October 2(	24	Complete		TRUE	Deleted from CPT
75820	Venography, e	Venography	January 2020	29				1.05	CMS-Othe	January 2(	XXX	1.05	2.30	NA	0.10	23689	FALSE			FALSE						TRUE	Increase
75822	Venography, e	Venography	January 2020	29				1.48	CMS-Othe	October 2(	XXX	1.48	2.51	NA	0.14	10692	FALSE			FALSE						TRUE	Increase
75885	Percutaneous	Interventional Radio	February 2009	21			ACR, SIR	New PE in	CMS Requ	NA	XXX	1.44	2.64	NA	0.10	348	FALSE			FALSE						TRUE	PE Only
75887	Percutaneous	Interventional Radio	February 2009	21			ACR, SIR	New PE in	CMS Requ	NA	XXX	1.44	2.68	NA	0.10	525	FALSE			FALSE						TRUE	PE Only
75894	Transcatheter	Transcatheter Proce	January 2021	29			ACC, ACR,	Maintain	Codes Rep	February 2	XXX	0	0.00	NA	0.00	9539	FALSE			FALSE	The Workgroup accepts t	RAW will assess Oct 2018				TRUE	Maintain
75896	Transcatheter	Intracranial Endovas	April 2015	09			AANS/CNS	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	AANS indicated that they	February 2	21 & 14	Complete		TRUE	Deleted from CPT
75898	Angiography tl	Intracranial Endovas	January 2019	37			AANS/CNS	Refer to CI	Codes Rep	February 2	XXX	0	0.00	NA	0.00	11637	TRUE	Septembe	complete	TRUE	The Workgroup accepts t	February 2	21	Complete		TRUE	Contractor Price
75940	Percutaneous	Major Vein Revision	April 2010	45			ACR, SIR, S	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The Workgroup accepts t	February 2	14	Code Delete		TRUE	Deleted from CPT
75945	Intravascular u	Intravascular Ultrasc	January 2015	07			ACC,SCAI,	Deleted fr	Final Rule	July 2014							FALSE			TRUE	A CCP was submitted for	October 2(	13	Complete		TRUE	Deleted from CPT
75946	Intravascular u	Intravascular Ultrasc	January 2015	07			ACC,SCAI,	Deleted fr	Final Rule	July 2014							FALSE			TRUE	A CCP was submitted for	October 2(	13	Complete		TRUE	Deleted from CPT
75952	Endovascular r	Endovascular Repair	January 2017	10			SVS, SIR, S	Deleted fr	Codes Rep	October 2015							FALSE			FALSE						TRUE	Deleted from CPT
75953	Placement of p	Endovascular Repair	January 2017	10			SVS, SIR, S	Deleted fr	Codes Rep	October 2015							FALSE			FALSE						TRUE	Deleted from CPT
75954	Endovascular r	Endovascular Repair	January 2017	10			SVS, SIR, S	Deleted fr	Codes Rep	January 2017							FALSE			FALSE						TRUE	Deleted from CPT
75960	Transcatheter	RAW	October 2012	27			ACC, ACR,	Deleted fr	High Volume Growth1 / Codes Reported Together 75% or More-Part1								FALSE			TRUE	In February 2010, the CPT	February 2	10	Code Delete		TRUE	Deleted from CPT
75961	Transcatheter	Transcatheter Proce	April 2010	45			ACC, ACR,	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The Workgroup accepts t	June 2011		Code Delete		TRUE	Deleted from CPT
75962	Transluminal b	Open and Percutane	January 2016	15			ACR, SIR, S	Deleted fr	High Volur	April 2010							FALSE			TRUE	The Workgroup accepted	October 2(	24	Complete		TRUE	Deleted from CPT
75964	Transluminal b	Open and Percutane	January 2016	15			ACR, SIR, S	Deleted fr	High Volume Growth1								FALSE			TRUE	In February 2010, the CPT	October 2(	24	Complete		TRUE	Deleted from CPT
75966	Transluminal b	Open and Percutane	January 2016	15			ACR, SIR, S	Deleted fr	Codes Rep	January 2015							FALSE			TRUE	In January 2015, the Joint	October 2(	24	Complete		TRUE	Deleted from CPT
75968	Transluminal b	Open and Percutane	January 2016	15			ACR, SIR, S	Deleted fr	Codes Rep	January 2015							FALSE			TRUE	In January 2015, the Joint	October 2(	24	Complete		TRUE	Deleted from CPT
75978	Transluminal b	Open and Percutane	January 2016	15			ACR, SIR, S	Deleted fr	CMS-Othe	April 2013							FALSE			TRUE	CPT code 75978 was iden	October 2(	24	Complete		TRUE	Deleted from CPT
75980	Percutaneous	Percutaneous Biliary	October 2015	06	RUC		ACR, SIR	Deleted fr	Codes Rep	October 2012							FALSE			TRUE	The Joint Workgroup rec	February 2	16	Complete		TRUE	Deleted from CPT
75982	Percutaneous	Percutaneous Biliary	October 2015	06	RUC		ACR, SIR	Deleted fr	Codes Rep	October 2012							FALSE			TRUE	The Joint Workgroup rec	February 2	16	Complete		TRUE	Deleted from CPT
75984	Change of per	Introduction of Cath	April 2019	17			ACR, SIR	0.83	Codes Rep	October 2(	XXX	0.83	2.17	NA	0.05	20664	FALSE			FALSE	The Joint Workgroup rec	RAW will assess Oct 2018				TRUE	Increase
75992	Deleted from (	Transluminal Arthre	April 2008	57			SIR, ACR, S	Deleted fr	High Volur	February 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Deleted-ne		TRUE	Deleted from CPT
75993	Deleted from (	Transluminal Arthre	April 2008	57			SIR, ACR, S	Deleted fr	High Volur	February 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Deleted-ne		TRUE	Deleted from CPT
75994	Revised to Cat	Transluminal Arthre	April 2008	57			SIR, ACR, S	Deleted fr	High Volur	April 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Category III		TRUE	Deleted from CPT
75995	Revised to Cat	Transluminal Arthre	April 2008	57			SIR, ACR, S	Deleted fr	High Volur	April 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Category III		TRUE	Deleted from CPT
75996	Revised to Cat	Transluminal Arthre	April 2008	57			SIR, ACR, S	Deleted fr	High Volur	April 2008							FALSE			TRUE	The RUC recommended t	February 2	07	Category III		TRUE	Deleted from CPT
76000	Fluoroscopy (s	Fluoroscopy	April 2017	27			ACR, APM,	0.30	Low Value	October 2(	XXX	0.3	0.90	NA	0.05	118492	FALSE			FALSE						TRUE	Increase
76001	Fluoroscopy, p	Fluoroscopy	April 2017	27			ACR	Deleted fr	CMS-Othe	October 2016							FALSE			TRUE	In April 2017 the specialt	Septembe 27		complete		TRUE	Deleted from CPT
76098	Radiological ex	X-Ray Exam Specime	October 2018	21			ACR	0.31	CMS-Othe	October 2(	XXX	0.31	0.89	NA	0.03	68182	FALSE			FALSE						TRUE	Increase
76100	Radiologic exa	Fluroscopy	April 2009	27			ACR, ISIS	New PE in	CMS Requ	April 2009	XXX	0.58	2.12	NA	0.05	5269	FALSE			FALSE						TRUE	PE Only
76101	Radiologic exa	Fluroscopy	April 2009	27			ACR, ISIS	New PE in	CMS Requ	April 2009	XXX	0.58	2.30	NA	0.15	2	FALSE			FALSE						TRUE	PE Only
76102	Radiologic exa	Fluroscopy	April 2009	27			ACR, ISIS	New PE in	CMS Requ	April 2009	XXX	0.58	4.65	NA	0.08	2408	FALSE			FALSE						TRUE	PE Only
76376	3d rendering w	3D Rendering	April 2018	23			ACR, ASNR	0.20	Negative I'	April 2017	XXX	0.2	0.44	NA	0.02	276317	FALSE			FALSE						TRUE	Maintain
76377	3d rendering w	3D Rendering with In	October 2021	17			ACR, ASNR	0.79	CMS Requ	July 2019	XXX	0.79	1.24	NA	0.05	190343	FALSE			FALSE						TRUE	Maintain
76510	Ophthalmic ult	Opthalmic Ultrasour	October 2016	23	RUC		AAO, ASRS	0.70	CMS High	April 2016	XXX	0.7	1.41	NA	0.02	14435	FALSE			FALSE						TRUE	Decrease
76511	Ophthalmic ult	Opthalmic Ultrasour	October 2016	23	RUC		AAO, ASRS	0.64	CMS High	April 2016	XXX	0.64	1.02	NA	0.02	4208	FALSE			FALSE						TRUE	Decrease
76512	Ophthalmic ult	Opthalmic Ultrasour	October 2016	23	RUC		AAO, ASRS	0.56	CMS High	July 2015	XXX	0.56	0.85	NA	0.02	220526	FALSE			FALSE						TRUE	Decrease
76513	Ophthalmic ult	Ophthalmic Ultraso	January 2020	17			AAO, AOA	0.60 and C	High Volur	February 2	XXX	0.6	1.67	NA	0.02	26263	TRUE	Apr 2013	Yes	TRUE	At the April 2019 RUC me	Septembe 28		yes		TRUE	Decrease
76514	Ophthalmic ult	Echo Exam of Eye Th	October 2017	12			AAO, AOA	0.17	Negative I'	April 2017	XXX	0.14	0.18	NA	0.02	488963	FALSE			FALSE						TRUE	Maintain
76516	Ophthalmic bi	Opthalmic Biometry	April 2016	36			AAO, AOA	0.40	CMS High	April 2016	XXX	0.4	0.94	NA	0.02	2403	FALSE			FALSE						TRUE	Decrease
76519	Ophthalmic bi	Opthalmic Biometry	April 2016	36			AAO, AOA	0.54	CMS High	July 2015	XXX	0.54	1.40	NA	0.02	187253	FALSE			FALSE						TRUE	Maintain
76536	Ultrasound, so	Soft Tissue Ultrasou	April 2009	29			ACR, ASNR	0.56	CMS Faste	October 2(	XXX	0.56	2.81	NA	0.05	945181	FALSE			FALSE						TRUE	Maintain
76604	Ultrasound, ch	Ultrasound Exam - C	April 2018	24			ACR	0.59	CMS-Othe	October 2(	XXX	0.59	1.32	NA	0.05	106091	FALSE			FALSE						TRUE	Increase
76641	Ultrasound, br	Breast Ultrasound	January 2014	13			ACR	0.73	CMS-Othe	January 2(	XXX	0.73	2.34	NA	0.05	647984	FALSE			FALSE		October 2(	26	Complete		TRUE	Increase
76642	Ultrasound, br	Breast Ultrasound	January 2014	13			ACR	0.68	CMS-Othe	January 2(	XXX	0.68	1.84	NA	0.05	769119	FALSE			FALSE		October 2(	26	Complete		TRUE	Increase
76645	Ultrasound, br	Breast Ultrasound	January 2014	13			ACR	Deleted fr	CMS-Othe	April 2011							FALSE			TRUE	Code 76645, Ultrasound,	October 2(	26	Complete		TRUE	Deleted from CPT
76700	Ultrasound, ab	Ultrasound	October 2013	13			ACR	0.81	MPC List	October 2(	XXX	0.81	2.71	NA	0.05	908859	FALSE			FALSE						TRUE	Maintain
76705	Ultrasound, ab	Ultrasound	October 2013	13			ACR, ASBS	0.59	CMS-Othe	April 2011	XXX	0.59	2.03	NA	0.05	1100059	FALSE			FALSE						TRUE	Maintain
76706	Ultrasound, ab	Abdominal Aorta Ult	October 2015	12			ACR, SIR, S	0.55	Final Rule	May 2015	XXX	0.55	2.62	NA	0.05	159273	TRUE	Jan 2017	Yes	FALSE		May 2015	23	Complete		TRUE	Decrease
76770	Ultrasound, re	Ultrasound	October 2013	13			ACR	0.74	CMS-Othe	April 2011	XXX	0.74	2.51	NA	0.05	1345427	FALSE			FALSE						TRUE	Maintain
76775	Ultrasound, re	Ultrasound	October 2013	13			ACR	0.58	CMS-Othe	April 2011	XXX	0.58	1.09	NA	0.05	522183	FALSE			FALSE						TRUE	Maintain
76819	Fetal biophysic	RAW	October 2013	18				Remove fr	High Volur	April 2013	XXX	0.77	1.71	NA	0.05	12225	FALSE			FALSE						TRUE	Remove from screen

76830	Ultrasound, tra	Transvaginal and Tra	April 2012	44			ACOG, ACI	0.69	CMS High	Septembe	XXX	0.69	2.90	NA	0.05	442342	FALSE			FALSE							TRUE	Maintain		
76856	Ultrasound, pe	Ultrasound	October 2013	13			ACR	0.69	CMS-Othe	April 2011	XXX	0.69	2.48	NA	0.05	429962	FALSE			FALSE							TRUE	Maintain		
76857	Ultrasound, pe	Ultrasound	October 2013	13			ACR	0.50	CMS-Othe	April 2013	XXX	0.5	0.87	NA	0.03	205984	FALSE			FALSE							TRUE	Decrease		
76870	Ultrasound, sc	Ultrasound Exam - S	April 2017	28			ACR, AUA	0.64	CMS-Othe	April 2016	XXX	0.64	2.39	NA	0.05	147467	FALSE			FALSE							TRUE	Maintain		
76872	Ultrasound, tra	Transvaginal and Tra	April 2012	44			ACOG, ACI	0.69	CMS High	Septembe	XXX	0.69	4.79	NA	0.03	212765	FALSE			FALSE							TRUE	Maintain		
76880	Deleted from (	Lower Extremity Ult	October 2009	26			APMA, AC	Deleted fr	CMS Faste	October 2008							FALSE			TRUE	The RUC recommended a	February 2	37	Deleted	TRUE	Deleted from CPT			
76881	Ultrasound, co	Neuromuscular Ultra	October 2019	17	January 2(	RUC	AAN, AAN	Survey	CMS Faste	April 2010	XXX	0.63	1.28	NA	0.03	196753	TRUE	Clinical Exa	Yes	TRUE	In February 2010, the CPT	June 2017	13	yes	FALSE				
76882	Ultrasound, lin	Neuromuscular Ultra	October 2019	17	January 2(	RUC	AAN, AAN	Survey	CMS Faste	April 2010	XXX	0.49	1.13	NA	0.03	288120	TRUE	Clinical Exa	Yes	TRUE	In February 2010, the CPT	June 2017	13	yes	FALSE	Decrease			
76930	Ultrasonic guic	Pericardiocentesis a	January 2019	04			ACC	Deleted fr	CMS Requ	July 2013						2662	FALSE			FALSE		Septembe	14	Complete	TRUE	Deleted from CPT			
76932	Ultrasonic guic	Ultrasound Guidanc	April 2014	34			ACC	0.67	CMS Requ	July 2013	YYY	0	0.00	NA	0.00	1241	FALSE			FALSE					TRUE	Maintain		
76936	Ultrasound gui	RAW	October 2013	18				Maintain	CMS Requ	July 2013	XXX	1.99	5.68	NA	0.25	810	FALSE			FALSE					TRUE	Maintain		
76937	Ultrasound gui	PICC Line Procedure	January 2018	09	April 2022	RUC		Survey in 2	Identified	January 2(	ZZZ	0.3	0.80	NA	0.02	637782	FALSE			FALSE					FALSE				
76940	Ultrasound gui	Ultrasound Guidanc	January 2015	29			ACS, ACR,	2.00	CMS Requ	July 2013	YYY	0	0.00	NA	0.00	1403	FALSE			FALSE					TRUE	Maintain		
76942	Ultrasonic guic	Somatic Nerve Injec	October 2021	05			AAPM, AA	0.67	CMS-Othe	April 2011	XXX	0.67	0.97	NA	0.05	1178266	FALSE			TRUE	During the October 2018	May 2021	14	complete	TRUE	Maintain			
76948	Ultrasonic guic	Echo Guidance for C	January 2015	25			ACOG	0.85	CMS Requ	July 2013	XXX	0.67	1.65	NA	0.03	3	FALSE			FALSE					TRUE	Increase			
76950	Ultrasonic guic	Ultrasound Guidanc	April 2014	34				Deleted fr	Codes Rep	February 2010							FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	Deleted from CPT			
76965	Ultrasonic guic	Ultrasound Guidanc	September 201	21			NO INTERI	Maintain	CMS Requ	July 2013	XXX	1.34	1.31	NA	0.05	6316	FALSE			FALSE					TRUE	Maintain			
76970	Ultrasound stu	IMRT with Ultrasour	October 2019	17			ACS, ACR,	Deleted fr	High Volur	February 2008						25085	FALSE			TRUE	In October 2018, the Wor	February 2	9	Complete	TRUE	Deleted from CPT			
76998	Ultrasonic guidance, intraoperative		October 2019	17	April 2022	RUC	STS, AATS,	Refer to CI	CMS-Othe	January 2(	XXX	0	0.00	NA	0.00	29381	FALSE			TRUE	In October 2018, the Wor	February 2022			FALSE				
77001	Fluoroscopic g	PICC Line Procedure	January 2018	09		RUC	AANS, AAI	0.38	MPC List /	January 2(	ZZZ	0.38	2.58	NA	0.05	310854	FALSE			TRUE	In the NPRM for 2015, CM	October 2015		Complete	TRUE	Maintain			
77002	Fluoroscopic g	Somatic Nerve Injec	October 2021	05			AAPM, AA	0.54	MPC List /	January 2(	ZZZ	0.54	2.82	NA	0.05	528759	FALSE			TRUE	In the NPRM for 2015, CM	October 2015		Complete	TRUE	Maintain			
77003	Fluoroscopic g	Somatic Nerve Injec	October 2021	05			AAPM, AA	0.60	MPC List /	October 2(	ZZZ	0.6	2.42	NA	0.05	77998	FALSE			TRUE	In the NPRM for 2015, CM	October 2015		Complete	TRUE	Maintain			
77011	Computed tom	IMRT with CT Guida	October 2010	15			ASTRO, AC	New PE in	CMS Request - Practi		XXX	1.21	5.59	NA	0.10	4582	FALSE			FALSE					TRUE	PE Only			
77012	Computed tom	Lung Biopsy-CT Guid	April 2019	05	April 2022		ACR, SIR	Bundled 3	CMS-Othe	April 2016	XXX	1.5	2.73	NA	0.10	210656	FALSE			TRUE	In October 2017, maintair	February 2	11	complete	TRUE	Increase			
77014	Computed tom	IMRT with CT Guida	October 2021	20			ASTRO, AC	Remove fr	CMS Requ	October 2(	XXX	0.85	2.72	NA	0.05	2401373	FALSE			FALSE	Revise based on CMS input regarding the radiation oncolog				TRUE	Maintain			
77031	Stereotactic lo	Breast Biopsy	April 2013	04				Deleted fr	Codes Rep	January 2012							FALSE			FALSE		October 2(	08	Complete	TRUE	Deleted from CPT			
77032	Mammograph	Breast Biopsy	April 2013	04				Deleted fr	Codes Rep	January 2012							FALSE			FALSE		October 2(	08	Complete	TRUE	Deleted from CPT			
77046	Magnetic reso	Breast MRI with Con	October 2017	06			ACR	1.45	CMS High	June 2017	XXX	1.45	5.44	NA	0.08	367	FALSE			FALSE		June 2017	14		TRUE	Decrease			
77047	Magnetic reso	Breast MRI with Con	October 2017	06			ACR	1.60	CMS High	June 2017	XXX	1.6	5.48	NA	0.08	4029	FALSE			FALSE		June 2017	14		TRUE	Decrease			
77048	Magnetic reso	Breast MRI with Con	October 2017	06			ACR	2.10	CMS High	June 2017	XXX	2.1	8.88	NA	0.12	1164	FALSE			FALSE		June 2017	14		TRUE	Increase			
77049	Magnetic reso	Breast MRI with Con	October 2017	06			ACR	2.30	CMS High	June 2017	XXX	2.3	8.91	NA	0.13	87710	FALSE			FALSE		June 2017	14		TRUE	Increase			
77051	Computer-aide	Mammography-Con	January 2016	20			ACR	Deleted fr	CMS-Other - Utilization over 250,000 / Final Rule for 2015								FALSE			FALSE		October 2(	38	Complete	TRUE	Deleted from CPT			
77052	Computer-aide	Mammography-Con	January 2016	20			ACR	Deleted fr	Low Value	October 2010							FALSE			FALSE		October 2(	38	Complete	TRUE	Deleted from CPT			
77055	Mammograph	Mammography-Con	January 2016	20			ACR	Deleted fr	CMS-Othe	January 2014							FALSE			TRUE	In the NPRM for 2015, CM	October 2(	38	Complete	TRUE	Deleted from CPT			
77056	Mammograph	Mammography-Con	January 2016	20			ACR	Deleted fr	CMS-Othe	January 2014							FALSE			TRUE	In the NPRM for 2015, CM	October 2(	38	Complete	TRUE	Deleted from CPT			
77057	Screening man	Mammography-Con	January 2016	20			ACR	Deleted fr	CMS-Othe	January 2014							FALSE			TRUE	In the NPRM for 2015, CM	October 2(	38	Complete	TRUE	Deleted from CPT			
77058	Magnetic reso	Breast MRI with Con	October 2017	06			ACR	Deleted fr	CMS High	July 2015							FALSE			TRUE	In preparation to survey (	June 2017	14	yes	TRUE	Deleted from CPT			
77059	Magnetic reso	Breast MRI with Con	October 2017	06			ACR	Deleted fr	CMS High	July 2015							FALSE			TRUE	In preparation to survey (	June 2017	14	yes	TRUE	Deleted from CPT			
77065	Diagnostic ma	Mammography-Con	January 2016	20			ACR	0.81	Final Rule	October 2(	XXX	0.81	2.90	NA	0.05	765901	FALSE			FALSE		October 2(	38	Complete	TRUE	Increase			
77066	Diagnostic ma	Mammography-Con	January 2016	20			ACR	1.00	Final Rule	October 2(	XXX	1	3.70	NA	0.06	612243	FALSE			FALSE		October 2(	38	Complete	TRUE	Increase			
77067	Screening man	Mammography-Con	January 2016	20			ACR	0.76	Final Rule	October 2(	XXX	0.76	3.04	NA	0.05	6106768	FALSE			FALSE		October 2(	38	Complete	TRUE	Maintain			
77073	Bone length st	X-Ray Exam - Bone	April 2018	25			AAOS, ACF	0.26	CMS-Othe	October 2(	XXX	0.26	1.03	NA	0.03	57827	FALSE			FALSE					TRUE	Decrease			
77074	Radiologic exa	X-Ray Exam - Bone	April 2018	25			ACR	0.44	CMS-Othe	October 2(	XXX	0.44	1.43	NA	0.03	4891	FALSE			FALSE					TRUE	Decrease			
77075	Radiologic exa	X-Ray Exam - Bone	April 2018	25			ACR	0.55	CMS-Othe	October 2(	XXX	0.55	2.29	NA	0.05	44120	FALSE			FALSE					TRUE	Increase			
77076	Radiologic exa	X-Ray Exam - Bone	April 2018	25			ACR	0.70	CMS-Othe	October 2(	XXX	0.7	2.36	NA	0.05	50	FALSE			FALSE					TRUE	Maintain			
77077	Joint survey, si	X-Ray Exam - Bone	April 2018	25			ACR	0.33	CMS-Othe	October 2(	XXX	0.33	1.01	NA	0.03	39322	FALSE			FALSE					TRUE	Increase			
77079	Computed tom	CT Bone Density Stu	February 2010	31			ACR, AAFP	Deleted fr	Different F	October 2009							FALSE			TRUE	The Workgroup recomme	October 2(	22	Complete	TRUE	Deleted from CPT			
77080	Dual-energy x	Dual Energy X-Ray	October 2013	07			AACE, ACN	0.20	CMS Requ	Septembe	XXX	0.2	0.89	NA	0.02	2624321	FALSE			TRUE	In Oct 2012, the Joint Wo	May 2013		Complete	TRUE	Maintain			
77081	Dual-energy x	Dual-energy X-Ray A	January 2018	25				0.20	Negative I	April 2017	XXX	0.2	0.70	NA	0.02	42987	FALSE			FALSE					TRUE	Decrease			
77082	Dual-energy X	Dual Energy X-Ray	October 2013	07			AACE, ACN	Deleted fr	CMS Requ	September 2011							FALSE			TRUE	In Oct 2012, the Joint Wo	May 2013		Complete	TRUE	Deleted from CPT			
77083	Radiographic a	Radiographic Absorp	February 2010	31			ACR, ACP	Deleted fr	Different F	October 2009							FALSE			TRUE	The Workgroup recomme	October 2(	22	Complete	TRUE	Deleted from CPT			
77085	Dual-energy x	Dual Energy X-Ray	October 2013	07			AACE, ACN	0.30	Codes Rep	October 2(	XXX	0.3	1.21	NA	0.02	110730	FALSE			FALSE	In Oct 2012, the Joint Wo	May 2013		Complete	TRUE	Decrease			
77086	Vertebral fract	Dual Energy X-Ray	October 2013	07			AACE, ACN	0.17	Codes Rep	October 2(	XXX	0.17	0.79	NA	0.02	1925	FALSE			FALSE	In Oct 2012, the Joint Wo	May 2013		Complete	TRUE	Maintain			
77261	Therapeutic ra	Radiation Therapy P	April 2016	37			ASTRO	1.30	CMS High	July 2015	XXX	1.3	0.67	0.67	0.09	9135	FALSE			FALSE					TRUE	Decrease			
77262	Therapeutic ra	Radiation Therapy P	April 2016	37			ASTRO	2.00	CMS High	July 2015	XXX	2	0.99	0.99	0.14	3526	FALSE			FALSE					TRUE	Decrease			
77263	Therapeutic ra	Radiation Therapy P	April 2016	37			ASTRO	3.14	CMS High	July 2015	XXX	3.14	1.51	1.51	0.22	297484	FALSE			FALSE					TRUE	Maintain			
77280	Therapeutic ra	Set Radiation Therap	January 2013	14			ASTRO	0.70	Harvard V	April 2011	XXX	0.7	7.55	NA	0.05	370105	FALSE			TRUE	ASTRO reviewed the proc	October 2(	22	Complete	TRUE	Maintain			
77285	Therapeutic ra	Respiratory Motion	January 2013	14			ASTRO	1.05	Harvard V	Septembe	XXX	1.05	12.64	NA	0.06	4612	FALSE			TRUE	ASTRO reviewed the proc	October 2(	22	Complete	TRUE	Maintain			
77290	Therapeutic ra	Respiratory Motion	January 2013	14			ASTRO	1.56	MPC List /	October 2(	XXX	1.56	12.74	NA	0.07	210211	FALSE			TRUE	ASTRO reviewed the proc	October 2(	22	Complete	TRUE	Maintain			
77293	Respiratory m	Respiratory Motion	January 2013	14			ASTRO	2.00	Harvard Valued - Utili		ZZZ	2	10.91	NA	0.13	31536	FALSE			FALSE		October 2(	22	Complete	TRUE	Decrease			
77295	3-dimensional	Surface Radionuclid	January 2013	14			ASTRO	4.29	Harvard V	Septembe	XXX	4.29	9.58	NA	0.20	142124	FALSE			TRUE	ASTRO reviewed the proc	October 2(	22, 28/29	Complete	TRUE	Decrease			
77300	Basic radiation	Surface Radionuclid	April 2014	20			ASTRO	0.62	MPC List /	October 2(	XXX	0.62	1.28	NA	0.03	1349820	FALSE			TRUE	On 8-21-12, the Joint Wo	February 2	44, 28/29	complete	TRUE	Maintain			
77301	Intensity modu	IMRT - PE Only	April 2013	28			ASTRO	New PE In	CMS Faste	October 2(	XXX	7.99	46.91	NA	0.56	143270	TRUE	Nov 2009	Yes	FALSE					TRUE	Maintain			
77305	Teletherapy, is	Isodose Calculation	April 2014	20			ASTRO	Deleted fr	Codes Rep	October 2010							FALSE			TRUE	On 8-21-12, the Joint Wo	February 2	44	Complete	TRUE	Deleted from CPT			
77306	Teletherapy isc	Isodose Calculation	April 2014	20				1.40	Codes Rep	October 2(	XXX	1.4	2.84	NA	0.07	2027	FALSE			FALSE					TRUE	Decrease			
77307	Teletherapy isc	Isodose Calculation	April 2014	20				2.90	Codes Rep	October 2(	XXX	2.9	5.33	NA	0.15	40701	FALSE			FALSE					TRUE	Decrease			
77310	Teletherapy, is	Isodose Calculation	April 2014	20			ASTRO	Deleted fr	Codes Rep	October 2010							FALSE			TRUE	On 8-21-12, the Joint Wo	February 2	44	Complete	TRUE	Deleted from CPT			
77315	Teletherapy, is	Isodose Calculation	April 2014	20			ASTRO	Deleted fr	Codes Rep	October 2010							FALSE			TRUE	On 8-21-12, the Joint Wo	February 2	44	Complete	TRUE	Deleted from CPT			
77316	Brachytherapy	Isodose Calculation	April 2014	20				1.50	Codes Rep	October 2(	XXX	1.4	5.29	NA	0.09	4610	FALSE			FALSE					TRUE	Decrease			
77317	Brachytherapy	Isodose Calculation	April 2014	20				1.83	Codes Rep	October 2(	XXX	1.83	6.96	NA	0.11	3179	FALSE			FALSE					TRUE	Decrease			
77318	Brachytherapy	Isodose Calculation	October 2015	21				2.90	Codes Rep	October 2(	XXX	2.9	9.61	NA	0.17	5949	FALSE			TRUE	On 8-21-12, the Joint Wo	February 2	44	Complete	TRUE	Decrease			
77326	Brachytherapy	Isodose Calculation	April 2014	20				Deleted fr	Codes Rep	October 2012							FALSE			TRUE	On 8-21-12, the Joint Wo	February 2	44	Complete	TRUE	Deleted from CPT			
77327	Brachytherapy	Isodose Calculation	April 2014	20			ASTRO	Deleted fr	Codes Rep	October 2010							FALSE			TRUE	On 8-21-12, the Joint Wo	February 2	44	Complete	TRUE	Deleted from CPT			
77328	Brachytherapy	Isodose Calculation	April 2014	20				Deleted fr	Codes Rep	October 2012							FALSE			TRUE	On 8-21-12, the Joint Wo	February 2	44	Complete	TRUE	Deleted from CPT			
77332	Treatment dev	RAW	January 2016	40		RUC	ASTRO	0.54	CMS High	April 2015	XXX	0.45	0.74	NA	0.03	75801	FALSE			FALSE					TRUE	Maintain			
77333	Treatment dev	RAW	January 2016	40		RUC	ASTRO	0.84	CMS High	April 2015	XXX	0.75	3.09	NA	0.05	12128	FALSE			FALSE					TRUE	Maintain			
77334	Treatment devices, design and con		January 2016	40		RUC	ASTRO	1.24	MPC List /	October 2(	XXX	1.15	2.47	NA	0.05	845243	FALSE			FALSE					TRUE	Maintain			
77336	Continuing me	Continuing Medical	April 2013	31			ASTRO	New PE In	CMS Requ	October 2(	XXX	0	2.31	NA	0.06	412038	FALSE			FALSE					TRUE	PE Only			
77338	Multi-leaf colli	IMRT - PE Only	April 2013	28				New PE In	Services w	October 2(	XXX	4.29	9.27	NA	0.21	165179	FALSE			FALSE					TRUE	PE Only			
77371	Radiation trea	Radiation Treatmen	April 2009	30			ASTRO	New PE in	CMS Requ	NA	XXX	0	0.00	0.00	0.00	100	FALSE			FALSE					TRUE	PE Only			

77372	Radiation treat	Radiation Treatment	October 2013	18			New PE In	Services w	October 2(	XXX	0	30.62	NA	0.15	818	FALSE			FALSE					TRUE	PE Only
77373	Stereotactic bo	Radiation Treatment	October 2013	18		ACR, ASTR	New PE in	Services w	July 2012	XXX	0	33.38	NA	0.21	33144	FALSE			FALSE					TRUE	PE Only
77385	Intensity modu	Radiation Treatment	January 2014	14		ACRO, AST	PE Only, re	Services w	January 2(	XXX	0	0.00	0.00	0.00		FALSE			FALSE		October 2(	28	Complete	TRUE	PE Only
77386	Intensity modu	Radiation Treatment	January 2014	14		ACRO, AST	PE Only, re	Services w	January 2(	XXX	0	0.00	0.00	0.00		FALSE			FALSE		October 2(	28	Complete	TRUE	PE Only
77387	Guidance for lo	Radiation Treatment	January 2014	14		ACRO, AST	0.58	Services w	January 2(	XXX	0	0.00	0.00	0.00		FALSE			FALSE		October 2(	28	Complete	TRUE	Decrease
77401	Radiation treat	Radiation Treatemen	January 2020	31			New PE In	High Volur	October 2(	XXX	0	1.25	NA	0.01	221049	FALSE			TRUE	In October 2018, this serv	May 2019	08	Withdrawn	TRUE	PE Only
77402	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	PE Only, re	Services w	October 2(	XXX	0	0.00	0.00	0.00		FALSE			TRUE	At the April 2013 RUC me	October 2(	28 & 45	Complete	TRUE	PE Only
77403	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	Services w	October 2012							FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	Deleted from CPT
77404	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	Services w	October 2012							FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	Deleted from CPT
77406	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	Services w	October 2012							FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	Deleted from CPT
77407	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	PE Only, re	Services w	October 2(	XXX	0	0.00	0.00	0.00		FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	PE Only
77408	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	Services w	October 2012							FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	Deleted from CPT
77409	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	Services w	October 2012							FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	Deleted from CPT
77411	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	Services w	October 2012							FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	Deleted from CPT
77412	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	PE Only, re	Services w	October 2(	XXX	0	0.00	0.00	0.00		FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	PE Only
77413	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	Services w	October 2012							FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	Deleted from CPT
77414	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	Services w	October 2012							FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	Deleted from CPT
77416	Radiation treat	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	Services w	October 2012							FALSE			TRUE	At the April 2013 RUC me	October 2(	28	Complete	TRUE	Deleted from CPT
77418	Intensity modu	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	CMS Faste	October 2008							TRUE	Nov 2009	Yes	TRUE		October 2(	28	Complete	TRUE	Deleted from CPT
77421	Stereoscopic X	Radiation Treatment	January 2014	14		ACRO, AST	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	In Jan 2012, the specialty	October 2(	28	Complete	TRUE	Deleted from CPT
77422	High energy ne	High Energy Neutror	April 2015	35	RUC	AAOS, ASP	Contractor	CMS Requ	November 2014							FALSE			FALSE					TRUE	Maintain
77423	High energy ne	High Energy Neutror	April 2015	35	RUC	AAOS, ASP	Contractor	CMS Requ	November	XXX	0	0.00	0.00	0.00		FALSE			FALSE					TRUE	Maintain
77427	Radiation treat	Radiation Treatment	January 2016	54		ASTRO	3.45. Rem	Site of Ser	Septembe	XXX	3.37	1.88	1.88	0.25	1043579	FALSE			TRUE	In October 2008 the RUC	June 2009	21	Complete	TRUE	Decrease
77435	Stereotactic bo	RAW	January 2017	30			Remove fr	High Volur	October 2(	XXX	11.87	5.81	5.81	0.86	38142	FALSE			FALSE					TRUE	Remove from screen
77470	Special treatm	Special Radiation Tre	January 2016	41		ASTRO	2.03	CMS High	July 2015	XXX	2.03	1.73	NA	0.10	91885	FALSE			FALSE					TRUE	Decrease
77520	Proton treatm	Proton Beam Treatn	April 2019	19		ASTRO	New PE In	Contractor	October 2(	XXX	0	0.00	0.00	0.00	256	FALSE			FALSE					TRUE	PE Only
77522	Proton treatm	Proton Beam Treatn	April 2019	19		ASTRO	New PE In	Contractor	January 2(	XXX	0	0.00	0.00	0.00	15881	FALSE			FALSE					TRUE	PE Only
77523	Proton treatm	Proton Beam Treatn	April 2019	19		ASTRO	New PE In	High Volur	October 2(	XXX	0	0.00	0.00	0.00	47302	FALSE			FALSE					TRUE	PE Only
77525	Proton treatm	Proton Beam Treatn	April 2019	19		ASTRO	New PE In	Contractor	October 2(	XXX	0	0.00	0.00	0.00	20144	FALSE			FALSE					TRUE	PE Only
77600	Hyperthermia,	Hyperthermia - PE C	April 2013	30			New PE In	Services w	October 2(	XXX	1.31	12.92	NA	0.10	5464	FALSE			FALSE					TRUE	PE Only
77767	Remote afterlo	Surface Radionuclide	January 2015	16		ASTRO, AC	1.05	Codes Rep	October 2(	XXX	1.05	6.09	NA	0.08	5362	FALSE			FALSE		October 2(	28/29	Complete	TRUE	Decrease
77768	Remote afterlo	Surface Radionuclide	January 2015	16		ASTRO, AC	1.40	Codes Rep	October 2(	XXX	1.4	9.17	NA	0.10	7665	FALSE			FALSE		October 2(	28/29	Complete	TRUE	Decrease
77770	Remote afterlo	Surface Radionuclide	January 2015	16		ASTRO, AC	1.95	Codes Rep	October 2(	XXX	1.95	8.07	NA	0.11	17117	FALSE			FALSE		October 2(	28/29	Complete	TRUE	Decrease
77771	Remote afterlo	Surface Radionuclide	January 2015	16		ASTRO, AC	3.80	Codes Rep	October 2(	XXX	3.8	13.63	NA	0.23	17697	FALSE			FALSE		October 2(	28/29	Complete	TRUE	Decrease
77772	Remote afterlo	Surface Radionuclide	January 2015	16		ASTRO, AC	5.40	Codes Rep	October 2(	XXX	5.4	20.66	NA	0.35	4164	FALSE			FALSE		October 2(	28/29	Complete	TRUE	Decrease
77776	Interstitial radi	Interstitial Radiation	April 2015	17		ACR, ASTR	Deleted fr	Codes Rep	February 2015							FALSE			FALSE		February 2	35	Complete	TRUE	Deleted from CPT
77777	Interstitial radi	Interstitial Radiation	April 2015	17		ACR, ASTR	Deleted fr	Codes Rep	February 2015							FALSE			FALSE		February 2	35	Complete	TRUE	Deleted from CPT
77778	Interstitial radi	Interstitial Radiation	October 2015	21		ACR, ASTR	8.78	Codes Rep	October 2(	000	8.78	16.56	NA	0.46	4806	FALSE			TRUE	The Joint Workgroup reco	February 2	35	Complete	TRUE	Decrease
77781	Deleted from C	Brachytherapy	October 2008	26		ASTRO	Deleted fr	CMS Faste	October 2008							FALSE			TRUE	Deleted from CPT at Febr	February 2	36	Code Delete	TRUE	Deleted from CPT
77782	Deleted from C	Brachytherapy	February 2008	S		ASTRO	Deleted fr	High Volur	February 2008							FALSE			TRUE	Deleted from CPT at Febr	February 2	36	Code Delete	TRUE	Deleted from CPT
77784	Deleted from C	Brachytherapy	February 2008	S		ASTRO	Deleted fr	CMS Faste	February 2008							FALSE			TRUE	Deleted from CPT at Febr	February 2	36	Code Delete	TRUE	Deleted from CPT
77785	Remote afterlo	Surface Radionuclide	January 2015	16		ASTRO	Deleted fr	High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services								FALSE			TRUE	In October 2012, the Join	October 2(	28/29	Complete	TRUE	Deleted from CPT
77786	Remote afterlo	Surface Radionuclide	January 2015	16		ASTRO	Deleted fr	High Volume Growth1 / CMS Fastest Growing/CMS Request - Practice Expense / Services								FALSE			TRUE	In October 2012, the Join	October 2(	28/29	Complete	TRUE	Deleted from CPT
77787	Remote afterlo	Surface Radionuclide	January 2015	16		ASTRO	Deleted fr	High Volur	October 2012							FALSE			TRUE	In October 2012, the Join	October 2(	28/29	Complete	TRUE	Deleted from CPT
77790	Supervision, ha	Interstitial Radiation	October 2015	21		ACR, ASTR	0.00	Codes Rep	October 2(	XXX	0	0.44	NA	0.01	145	FALSE			TRUE	The Joint Workgroup reco	February 2	35	Complete	TRUE	Decrease
78000	Thyroid uptake	Thyroid Uptake/Ima	April 2012	22		ACR, ACNM	Deleted fr	Harvard Valued - Utilization over 30,000								FALSE			TRUE	Identified with 78007. Th	February 2	13	Complete	TRUE	Deleted from CPT
78001	Thyroid uptake	Thyroid Uptake/Ima	April 2012	22		ACR, ACNM	Deleted fr	Harvard Valued - Utilization over 30,000								FALSE			TRUE	Identified with 78007. Th	February 2	13	Complete	TRUE	Deleted from CPT
78003	Thyroid uptake	Thyroid Uptake/Ima	April 2012	22		ACR, ACNM	Deleted fr	Harvard Valued - Utilization over 30,000								FALSE			TRUE	Identified with 78007. Th	February 2	13	Complete	TRUE	Deleted from CPT
78006	Thyroid imagin	Thyroid Uptake/Ima	April 2012	22		ACR, ACNM	Deleted fr	Harvard Valued - Utilization over 30,000								FALSE			TRUE	Identified with 78007. Th	February 2	13	Complete	TRUE	Deleted from CPT
78007	Thyroid imagin	Thyroid Uptake/Ima	April 2012	22		ACR, ACNM	Deleted fr	Harvard V	April 2011							FALSE			TRUE	Specialty requests referra	February 2	13	Complete	TRUE	Deleted from CPT
78010	Thyroid imagin	Thyroid Uptake/Ima	April 2012	22		ACR, ACNM	Deleted fr	Harvard Valued - Utilization over 30,000								FALSE			TRUE	Identified with 78007. Th	February 2	13	Complete	TRUE	Deleted from CPT
78011	Thyroid imagin	Thyroid Uptake/Ima	April 2012	22		ACR, ACNM	Deleted fr	Harvard Valued - Utilization over 30,000								FALSE			TRUE	Identified with 78007. Th	February 2	13	Complete	TRUE	Deleted from CPT
78012	Thyroid uptake	Thyroid Uptake/Ima	April 2012	22		ACR, ACNM	0.19	Harvard Valued - Util		XXX	0.19	2.16	NA	0.05	1653	FALSE			TRUE	Identified with 78007 and	February 2	13	Complete	TRUE	Decrease
78013	Thyroid imagin	Thyroid Uptake/Ima	April 2012	22		ACR, ACNM	0.37	Harvard Valued - Util		XXX	0.37	5.33	NA	0.05	1711	FALSE			TRUE	Identified with 78007 and	February 2	13	Complete	TRUE	Decrease
78014	Thyroid imagin	Thyroid Uptake/Ima	April 2012	22		ACR, ACNM	0.50	Harvard Valued - Util		XXX	0.5	6.47	NA	0.06	18954	FALSE			TRUE	Identified with 78007 and	February 2	13	Complete	TRUE	Decrease
78070	Parathyroid pla	Parathyroid Imaging	January 2016	54		ACR, ACNM	0.80	Harvard V	April 2011	XXX	0.8	7.80	NA	0.08	13220	TRUE	Dec 2016	yes	FALSE					TRUE	Maintain
78071	Parathyroid pla	Parathyroid Imaging	January 2016	54		ACR, ACNM	1.20	Harvard V	April 2011	XXX	1.2	9.06	NA	0.10	8974	TRUE	Dec 2016	yes	FALSE					TRUE	Maintain
78072	Parathyroid pla	Parathyroid Imaging	January 2016	54		ACR, ACNM	1.60	Harvard V	April 2011	XXX	1.6	11.34	NA	0.10	12267	TRUE	Dec 2016	yes	FALSE					TRUE	Maintain
78223	Hepatobiliary d	Hepatobiliary Ductal	February 2011	12		ACR, SNM	Deleted fr	Harvard V	October 2009							FALSE			TRUE	The specialties will be sub	October 2(	21	Complete	TRUE	Deleted from CPT
78226	Hepatobiliary s	Hepatobiliary Systen	February 2011	12		ACR, SNM,	0.74	Harvard Valued - Util		XXX	0.74	8.80	NA	0.09	61197	FALSE			FALSE					TRUE	Decrease
78227	Hepatobiliary s	Hepatobiliary Systen	February 2011	12		ACR, SNM,	0.90	Harvard Valued - Util		XXX	0.9	11.97	NA	0.09	64389	FALSE			FALSE					TRUE	Decrease
78265	Gastric emptyi	Colon Transit Imagin	April 2015	18		ACNM, AC	CPT Assist	New code	April 2015	XXX	0.98	10.46	NA	0.09	1303	TRUE	Dec 2015	yes	FALSE					TRUE	Not Part of RAW
78266	Gastric emptyi	Colon Transit Imagin	April 2015	18		ACNM, AC	CPT Assist	New code	April 2015	XXX	1.08	11.62	NA	0.10	313	TRUE	Dec 2015	yes	FALSE					TRUE	Not Part of RAW
78278	Acute gastroin	Acute GI Blood Loss	September 201	34		ACR, SNM,	0.99	Harvard V	April 2011	XXX	0.99	9.16	NA	0.09	26257	FALSE			FALSE					TRUE	Maintain
78300	Bone and/or jo	Bone Imaging	April 2016	38		ACNM, AC	0.62	CMS High	July 2015	XXX	0.62	6.06	NA	0.08	6808	FALSE			FALSE					TRUE	Maintain
78305	Bone and/or jo	Bone Imaging	April 2016	38		ACNM, AC	0.83	CMS High	July 2015	XXX	0.83	7.27	NA	0.08	1645	FALSE			FALSE					TRUE	Maintain
78306	Bone and/or jo	Bone Imaging	April 2016	38		ACNM, AC	0.86	CMS High	July 2015	XXX	0.86	7.86	NA	0.08	262283	FALSE			FALSE					TRUE	Maintain
78429	Myocardial ima	Myocardial PET	January 2019	13		ACC, ACR,	1.76	High Volur	May 2018	XXX	0	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78430	Myocardial ima	Myocardial PET	January 2019	13		ACC, ACR,	1.67	High Volur	May 2018	XXX	0	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78431	Myocardial ima	Myocardial PET	January 2019	13		ACC, ACR,	1.90	High Volur	May 2018	XXX	0	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78432	Myocardial ima	Myocardial PET	January 2019	13		ACC, ACR,	2.07	High Volur	May 2018	XXX	0	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78433	Myocardial ima	Myocardial PET	January 2019	13		ACC, ACR,	2.26	High Volur	May 2018	XXX	0	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78434	Absolute quan	Myocardial PET	January 2019	13		ACC, ACR,	0.63	High Volur	May 2018	ZZZ	0	0.00	NA	0.00		FALSE			FALSE					TRUE	Increase
78451	Myocardial per	Myocardial Perfusio	February 2009	16		SNM, ACR,	1.40	Codes Rep	NA	XXX	1.38	8.53	NA	0.10	35912	FALSE			FALSE					TRUE	Increase
78452	Myocardial per	Myocardial Perfusio	February 2009	16		SNM, ACR,	1.75	Codes Rep	NA	XXX	1.62	12.21	NA	0.11	1787846	FALSE			FALSE					TRUE	Decrease
78453	Myocardial per	Myocardial Perfusio	February 2009	16		SNM, ACR,	1.00	Codes Rep	NA	XXX	1	7.72	NA	0.08	1518	FALSE			FALSE					TRUE	Decrease
78454	Myocardial per	Myocardial Perfusio	February 2009	16		SNM, ACR,	1.34	Codes Rep	NA	XXX	1.34	11.29	NA	0.10	10009	FALSE			FALSE					TRUE	Decrease
78459	Myocardial ima	Myocardial PET	January 2019	13		ACC, ACR,	1.61	High Volur	May 2018	XXX	0	0.00	NA	0.00	3214	FALSE			FALSE					TRUE	Increase
78460	Deleted from C	Myocardial Perfusio	February 2009	16		SNM, ACR,	Deleted fr	Codes Reported Together 95% or More								FALSE			FALSE		October 2(	23		TRUE	Deleted from CPT
78461	Deleted from C	Myocardial Perfusio	February 2009	16		SNM, ACR,	Deleted fr	Codes Reported Together 95% or More								FALSE			FALSE		October 2(	23		TRUE	Deleted from CPT

78464	Deleted from (	Myocardial Perfusio	February 2009	16		SNM, ACR,	Deleted fr	Codes Reported Together 95% or More									FALSE			FALSE		October 2(	23			TRUE	Deleted from CPT
78465	Deleted from (	Myocardial Perfusio	February 2009	16		SNM, ACR,	Deleted fr	Codes Rep	February 2008								FALSE			TRUE	Referred to the CPT Edito	October 2(	23		Code Delete	TRUE	Deleted from CPT
78472	Cardiac blood	Cardiac Blood Pool I	September 201	35		ACC, ACR,	0.98	Harvard Va	April 2011	XXX	0.98	5.64	NA	0.08	18051	FALSE			FALSE						TRUE	Maintain
78478	Deleted from (	Myocardial Perfusio	February 2009	16		SNM, ACR,	Deleted fr	Codes Rep	February 2008							FALSE			TRUE	Referred to the CPT Edito	October 2(	23		Code Delete	TRUE	Deleted from CPT
78480	Deleted from (	Myocardial Perfusio	February 2009	16		SNM, ACR,	Deleted fr	Codes Rep	February 2008							FALSE			TRUE	Referred to the CPT Edito	October 2(	23		Code Delete	TRUE	Deleted from CPT
78491	Myocardial im	Myocardial PET	January 2019	13		ACC, ACR,	1.56	High Volur	May 2018	XXX	0	0.00	NA	0.00	1809	FALSE			FALSE						TRUE	Increase
78492	Myocardial im	Myocardial PET	January 2019	13		ACC, ACR,	1.80	High Volur	October 2(	XXX	0	0.00	NA	0.00	179360	FALSE			TRUE	This service was identifie	May 2018	28		Yes	TRUE	Increase
78579	Pulmonary ver	Pulmonary Imaging	February 2011	13		ACR, SNM	0.49	Harvard Va	February 2	XXX	0.49	4.95	NA	0.06	360	FALSE			TRUE		October 2(	23		Complete	TRUE	Decrease
78580	Pulmonary per	Pulmonary Imaging	February 2011	13		SNM, ACR	0.74	Harvard Va	February 2	XXX	0.74	6.14	NA	0.08	10224	FALSE			TRUE	The specialties recomme	October 2(	23		Code Delete	TRUE	Maintain
78582	Pulmonary ver	Pulmonary Imaging	February 2011	13		ACR, SNM	1.07	Harvard Va	February 2	XXX	1.07	8.63	NA	0.09	165031	FALSE			TRUE		October 2(	23		Complete	TRUE	Decrease
78584	Pulmonary per	Pulmonary Perfusio	February 2010	31		SNM, ACR	Deleted fr	Harvard Va	February 2010							FALSE			TRUE	The specialties recomme	October 2(	23		Code Delete	TRUE	Deleted from CPT
78585	Pulmonary per	Pulmonary Perfusio	February 2010	31		SNM, ACR	Deleted fr	Harvard Va	October 2009							FALSE			TRUE	The specialties recomme	October 2(	23		Code Delete	TRUE	Deleted from CPT
78586	Pulmonary ver	Pulmonary Perfusio	February 2010	31		SNM, ACR	Deleted fr	Harvard Va	February 2010							FALSE			TRUE	The specialties recomme	October 2(	23		Code Delete	TRUE	Deleted from CPT
78587	Deleted from (	Pulmonary Perfusio	February 2010	31		SNM, ACR	Deleted fr	Harvard Va	February 2010							FALSE			TRUE	The specialties recomme	October 2(	23		Code Delete	TRUE	Deleted from CPT
78588	Deleted from (	Pulmonary Perfusio	February 2010	31		SNM, ACR	Deleted fr	Harvard Va	February 2010							FALSE			TRUE	The specialties recomme	October 2(	23		Code Delete	TRUE	Deleted from CPT
78591	Deleted from (	Pulmonary Perfusio	February 2010	31		SNM, ACR	Deleted fr	Harvard Va	February 2010							FALSE			TRUE	The specialties recomme	October 2(	23		Code Delete	TRUE	Deleted from CPT
78593	Deleted from (	Pulmonary Perfusio	February 2010	31		SNM, ACR	Deleted fr	Harvard Va	February 2010							FALSE			TRUE	The specialties recomme	October 2(	23		Code Delete	TRUE	Deleted from CPT
78594	Deleted from (	Pulmonary Perfusio	February 2010	31		SNM, ACR	Deleted fr	Harvard Va	February 2010							FALSE			TRUE	The specialties recomme	October 2(	23		Code Delete	TRUE	Deleted from CPT
78596	Deleted from (	Pulmonary Perfusio	February 2010	31		SNM, ACR	Deleted fr	Harvard Va	February 2010							FALSE			TRUE	The specialties recomme	October 2(	23		Code Delete	TRUE	Deleted from CPT
78597	Quantitative d	Pulmonary Imaging	February 2011	13		ACR, SNM	0.75	Harvard Va	February 2	XXX	0.75	5.12	NA	0.08	1640	FALSE			FALSE		October 2(	23			TRUE	Decrease
78598	Quantitative d	Pulmonary Imaging	February 2011	13		ACR, SNM	0.85	Harvard Va	February 2	XXX	0.85	8.01	NA	0.08	3383	FALSE			TRUE		October 2(	23		Complete	TRUE	Decrease
78803	Radiopharmac	RAW	January 2019	14		ACR, ACNI	1.20	Harvard Va	January 2(	XXX	1.09	10.20	NA	0.09	11736	TRUE	Dec 2016	yes	FALSE						TRUE	Increase
78815	Positron emission tomography (pet		February 2011	41		ACR, SNM	Reaffirme	MPC List	October 2(	XXX	0	0.00	NA	0.00	604627	FALSE			FALSE						TRUE	Maintain
79101	Radiopharmac	Radiopharmaceutica	February 2010	31		SNM, ACR	Article put	Different F	October 2(	XXX	1.96	2.28	NA	0.08	12142	TRUE	Feb 2012	Yes	FALSE						TRUE	Maintain
80500	Clinical pathol	Pathology Clinical Cc	January 2021	20		CAP	Deleted fr	CMS-Othe	January 2(	XXX	0.37	0.25	0.16	0.02	21998	FALSE			TRUE	In October 2018, the Wor	October 2(	50		complete	TRUE	Deleted from CPT
80502	Clinical pathol	Pathology Clinical Cc	January 2021	20		CAP	Deleted fr	CMS-Othe	January 2(	XXX	1.33	0.69	0.60	0.06	13114	FALSE			FALSE	In October 2018, the Wor	October 2(	50		complete	TRUE	Deleted from CPT
80503	Pathology clini	Pathology Clinical Cc	January 2021	20		CAP	0.50	CMS-Othe	January 2021							FALSE			FALSE	In October 2018, the Wor	October 2(	50		complete	TRUE	Decrease
80504	Pathology clini	Pathology Clinical Cc	January 2021	20		CAP	0.91	CMS-Othe	January 2021							FALSE			FALSE	In October 2018, the Wor	October 2(	50		complete	TRUE	Decrease
80505	Pathology clini	Pathology Clinical Cc	January 2021	20		CAP	1.80	CMS-Othe	January 2021							FALSE			FALSE	In October 2018, the Wor	October 2(	50		complete	TRUE	Decrease
80506	Pathology clini	Pathology Clinical Cc	January 2021	20		CAP	0.80	CMS-Othe	January 2021							FALSE			FALSE	In October 2018, the Wor	October 2(	50		complete	TRUE	Decrease
85060	Blood smear, p	Blood Smear Interpr	April 2017	30		CAP	0.45	CMS-Othe	April 2016	XXX	0.45	NA	0.22	0.04	185409	FALSE			FALSE						TRUE	Maintain
85097	Bone marrow,	Bone Marrow Interp	April 2017	31		CAP	1.00	CMS-Othe	April 2016	XXX	0.94	1.01	0.42	0.05	140727	FALSE			FALSE						TRUE	Increase
85390	Fibrinolysins o	Fibrinolysins Screen	January 2018	26			0.75	Negative I'	April 2017	XXX	0	0.00	0.00	0.00	34588	FALSE			FALSE						TRUE	Increase
88104	Cytopathology	Cytopathology	April 2015	36		AUR, ASC,	New PE In	Harvard Va	October 2(	XXX	0.56	1.35	NA	0.02	65152	FALSE			FALSE						TRUE	Maintain
88106	Cytopathology	Cytopathology	April 2015	36		AUR, ASC,	New PE In	Harvard Va	February 2	XXX	0.37	1.53	NA	0.02	5360	FALSE			FALSE						TRUE	Maintain
88107	Deleted from (	Cytopathology	October 2010	17		AUR, ASC,	Deleted fr	Harvard Va	February 2010							FALSE			TRUE	This service was brought	October 2(	30		Complete	TRUE	Deleted from CPT
88108	Cytopathology	Cytopathology Conc	April 2015	36	RUC	ACR, CAP	New PE In	Harvard Va	February 2	XXX	0.44	1.37	NA	0.02	229625	FALSE			FALSE						TRUE	Maintain
88112	Cytopathology	Cytopathology Conc	April 2015	36	RUC	ACR, CAP	New PE In	CMS High	Septembe	XXX	0.56	1.36	NA	0.02	886295	FALSE			FALSE	In January 2012 the specialty requested that this service be					TRUE	Decrease
88120	Cytopathology	RAW review	October 2017	19			Utilization	CMS Requ	November	XXX	1.2	16.90	NA	0.04	49876	FALSE			FALSE						TRUE	Maintain
88121	Cytopathology	RAW review	October 2017	19			Utilization	CMS Requ	November	XXX	1	12.06	NA	0.03	28769	FALSE			FALSE						TRUE	Maintain
88141	Cytopathology	Cytopathology Cervi	April 2018	26		CAP	0.42	CMS-Othe	October 2(	XXX	0.26	0.36	0.36	0.01	55857	FALSE			FALSE						TRUE	Maintain
88160	Cytopathology	Cytopathology Conc	April 2015	36			New PE In	CMS Requ	April 2015	XXX	0.5	1.54	NA	0.02	8020	FALSE			FALSE						TRUE	PE Only
88161	Cytopathology	Cytopathology Conc	April 2015	36			New PE In	CMS Requ	April 2015	XXX	0.5	1.54	NA	0.02	4156	FALSE			FALSE						TRUE	PE Only
88162	Cytopathology	Cytopathology Conc	April 2015	36			New PE In	CMS Requ	April 2015	XXX	0.76	2.20	NA	0.03	1306	FALSE			FALSE						TRUE	PE Only
88184	Flow cytometr	Flow Cytometry	January 2016			CAP	New PE In	CMS High	July 2015	XXX	0	1.98	NA	0.02	104681	FALSE			FALSE						TRUE	PE Only
88185	Flow cytometr	Flow Cytometry	January 2016			CAP	New PE In	CMS High	July 2015	ZZZ	0	0.66	NA	0.00	1918080	FALSE			FALSE						TRUE	PE Only
88187	Flow cytometr	Flow Cytometry Inte	January 2016	42		CAP	0.74	CMS High	July 2015	XXX	0.74	0.27	0.27	0.04	42225	FALSE			FALSE						TRUE	Decrease
88188	Flow cytometr	Flow Cytometry Inte	January 2016	42		CAP	1.40	CMS High	July 2015	XXX	1.2	0.55	0.55	0.05	38197	FALSE			FALSE						TRUE	Decrease
88189	Flow cytometr	Flow Cytometry Inte	January 2016	42		CAP	1.70	CMS High	July 2015	XXX	1.7	0.65	0.65	0.09	222162	FALSE			FALSE						TRUE	Decrease
88300	Level i - surgic	Pathology Consultat	January 2012	24		AAD, AGA,	0.08 and n	Havard Va	February 2	XXX	0.08	0.35	NA	0.02	207562	FALSE			FALSE						TRUE	Maintain
88302	Level ii - surgic	Pathology Consultat	January 2012	24		AAD, AGA,	0.13 and n	Havard Va	February 2	XXX	0.13	0.77	NA	0.02	75443	FALSE			FALSE						TRUE	Maintain
88304	Level iii - surgi	Pathology Consultat	January 2012	24		AAD, AGA,	0.22 and n	Havard Va	October 2(	XXX	0.22	0.97	NA	0.02	967907	FALSE			FALSE						TRUE	Maintain
88305	Level iv - surgi	Pathology Consultat	January 2012	24		AAD, AGA,	0.75 and n	Havard Va	October 2(	XXX	0.75	1.28	NA	0.02	17561979	FALSE			FALSE						TRUE	Maintain
88307	Level v - surgic	Pathology Consultat	January 2012	24		AAD, AGA,	1.59 and n	Havard Va	February 2	XXX	1.59	6.65	NA	0.08	983152	FALSE			FALSE						TRUE	Maintain
88309	Level vi - surgi	Pathology Services	January 2012	24		AAD, AGA,	2.80 and n	Havard Va	February 2	XXX	2.8	9.77	NA	0.09	150124	FALSE			FALSE						TRUE	Maintain
88312	Special stain in	Special Stains	January 2012	33		CAP	0.54	Havard Va	October 2(	XXX	0.54	2.68	NA	0.02	1383233	FALSE			TRUE	At the February 2010 RUC	June 2010	12		Complete	TRUE	Maintain
88313	Special stain in	Special Stains	February 2011	33		CAP	0.24	Havard Va	October 2(	XXX	0.24	2.08	NA	0.02	1362216	FALSE			TRUE	At the February 2010 RUC	June 2010	12		Complete	TRUE	Maintain
88314	Special stain in	Special Stains	February 2011	33		CAP	0.45	Havard Va	February 2	XXX	0.45	2.44	NA	0.02	21474	FALSE			TRUE	At the February 2010 RUC	June 2010	12		Complete	TRUE	Maintain
88318	Deleted from (	Special Stains	February 2010	22		CAP, AAD	Deleted fr	Havard Valued - Utilization over 1 Million								FALSE			TRUE	At the February 2010 RUC	June 2010	12		Complete	TRUE	Deleted from CPT
88319	Special stain in	Special Stains	February 2011	33		CAP	0.53	Havard Valued - Utiliz		XXX	0.53	3.17	NA	0.03	17807	FALSE			TRUE	At the February 2010 RUC	June 2010	12		Complete	TRUE	Maintain
88321	Consultation a	Microslide Consultat	January 2016	43		CAP, ASC	1.63	CMS High	July 2015	XXX	1.63	1.12	0.71	0.09	182148	FALSE			FALSE						TRUE	Maintain
88323	Consultation a	Microslide Consultat	January 2016	43		CAP, ASC	1.83	CMS High	July 2015	XXX	1.83	1.43	NA	0.03	35000	FALSE			FALSE						TRUE	Maintain
88325	Consultation, c	Microslide Consultat	January 2016	43		CAP, ASC	2.85	CMS High	July 2015	XXX	2.85	1.79	1.06	0.14	11656	FALSE			FALSE						TRUE	Increase
88329	Pathology con	Pathology Consultat	October 2010	18		CAP	0.67	Harvard Va	February 2	XXX	0.67	0.99	0.32	0.04	27870	FALSE			FALSE						TRUE	Maintain
88331	Pathology con	Pathology Consultat	October 2010	18		CAP	1.19	Harvard Va	October 2(	XXX	1.19	1.78	NA	0.03	448638	FALSE			FALSE						TRUE	Maintain
88332	Pathology con	Pathology Consultat	October 2010	18		CAP	0.59	Harvard Va	October 2(	XXX	0.59	0.97	NA	0.02	163257	FALSE			FALSE						TRUE	Maintain
88333	Pathology con	Pathology Consultat	April 2016	39		ASC, CAP	1.20	CMS Requ	July 2015	XXX	1.2	1.53	NA	0.03	69359	FALSE			FALSE						TRUE	Maintain
88334	Pathology con	Pathology Consultat	April 2016	39		ASC, CAP	0.73	CMS Requ	July 2015	ZZZ	0.73	0.90	NA	0.01	31996	FALSE			FALSE						TRUE	Maintain
88341	Immunohistoc	Morphometric Analy	April 2014	21		CAP	0.65	CMS Requ	November	ZZZ	0.56	2.12	NA	0.01	3097983	FALSE			FALSE						TRUE	Decrease
88342	Immunohistoc	Morphometric Analy	April 2014	21		CAP	0.70	CMS-Othe	April 2011	XXX	0.7	2.32	NA	0.02	2040539	FALSE			TRUE	In Jan 2012, the specialty	May 2012			Complete	TRUE	Decrease
88343	Immunohistoc	Morphometric Analy	April 2014	21		CAP	Deleted fr	CMS Requ	November 2013							FALSE			FALSE						TRUE	Deleted from CPT
88344	Immunohistoc	Morphometric Analy	April 2014	21		CAP	0.77	CMS Requ	November	XXX	0.77	4.32	NA	0.02	132224	FALSE			FALSE						TRUE	Decrease
88346	Immunofluore	Immunofluorescent	January 2015	17		CAP, ASC	0.74	CMS-Othe	April 2013	XXX	0.74	3.42	NA	0.02	61000	FALSE			TRUE	In April 2013, the RUC ide	October 2(	45		Complete	TRUE	Decrease
88347	Immunofluore	Immunofluorescent	January 2015	17		CAP, ASC	Deleted fr	CMS-Othe	October 2013							FALSE			TRUE	In April 2013, the RUC ide	October 2(	45		Complete	TRUE	Deleted from CPT
88348	Electron micro	Electron Microscopy	October 2013	14		CAP	New PE In	Services w	October 2(	XXX	1.51	10.80	NA	0.09	17170	FALSE			FALSE						TRUE	PE Only
88349	Electron micro	Electron Microscopy	October 2013	14		CAP	Deleted fr	Services w	October 2012							FALSE			TRUE	Refer to CPT to delete.	Oct 2013			Complete	TRUE	Deleted from CPT
88350	Immunofluore	Immunofluorescent	January 2015	17		CAP, ASC	0.70	CMS-Othe	October 2(	ZZZ	0.59	2.56	NA	0.02	260841	FALSE			FALSE	In April 2013, the RUC ide	October 2(	45		Complete	TRUE	Decrease
88356	Morphometric	RAW	April 2014	37		ASCP, CAP	2.80	High Volur	April 2013	XXX	2.8	4.11	NA	0.08	15440	FALSE			FALSE						TRUE	Decrease
88360	Morphometric	Tumor Immunohistc	April 2016	40		ASC, CAP	0.85	CMS High	July 2015	XXX	0.85	2.71	NA	0.02	506136	FALSE			FALSE						TRUE	Decrease
88361	Morphometric	Tumor Immunohistc	April 2016	40		ASC, CAP	0.95	CMS High	July 2015	XXX	0.95	2.59	NA	0.02	169281	FALSE			FALSE						TRUE	Decrease

88364	In situ hybridiz	Morphometric Analy	April 2014	21		CAP, ASCP	0.88	CMS Requ	November	ZZZ	0.7	3.42	NA	0.02	28908	FALSE			FALSE					TRUE	Decrease
88365	In situ hybridiz	Morphometric Analy	April 2014	21		CAP	0.88	CMS Requ	Septembe	XXX	0.88	4.41	NA	0.04	48038	TRUE	Dec 2011	Yes	TRUE	In April 2013, the College	May 2013	Complete		TRUE	Decrease
88366	In situ hybridiz	Morphometric Analy	April 2014	21		CAP, ASCP	1.24	CMS Requ	May 2013	XXX	1.24	7.13	NA	0.04	2322	FALSE			FALSE		May 2013	Complete		TRUE	Decrease
88367	Morphometric	Morphometric Analy	September 201	18		CAP, ASCP	0.86	CMS Requ	Septembe	XXX	0.73	2.57	NA	0.02	4914	TRUE	Dec 2011	Yes	TRUE	In April 2013, the College	May 2013	Complete		TRUE	Decrease
88368	Morphometric	Morphometric Analy	September 201	18		CAP, ASCP	0.88	CMS Requ	Septembe	XXX	0.88	3.02	NA	0.03	21780	TRUE	Dec 2011	Yes	TRUE	In April 2013, the College	May 2013	Complete		TRUE	Decrease
88373	Morphometric	Morphometric Analy	April 2014	21		CAP, ASCP	0.86	CMS Requ	November	ZZZ	0.58	1.51	NA	0.01	6229	FALSE			FALSE					TRUE	Decrease
88374	Morphometric	Morphometric Analy	April 2014	21		CAP, ASCP	1.04	CMS Request - Final F		XXX	0.93	9.15	NA	0.02	113039	FALSE			FALSE					TRUE	Decrease
88377	Morphometric	Morphometric Analy	October 2020	24		CAP, ASCP	1.40	CMS Requ	May 2013	XXX	1.4	10.73	NA	0.04	152595	FALSE			FALSE		May 2013	Complete		TRUE	Decrease
90460	Immunization	Immunization Admir	April 2021	19		AAFP, AAP	0.24	CMS Requ	July 2020	XXX	0.17	0.31	NA	0.01	301	FALSE			FALSE					TRUE	Increase
90461	Immunization	Immunization Admir	April 2021	19		AAFP, AAP	0.18	CMS Requ	July 2020	ZZZ	0.15	0.21	NA	0.01	58	FALSE			FALSE					TRUE	Increase
90465	Deleted from (	Immunization Admir	February 2008	R		AAP		New PE in	CMS Requ	NA						FALSE			FALSE					TRUE	Deleted from CPT
90467	Deleted from (	Immunization Admir	February 2008	R		AAP		New PE in	CMS Requ	NA						FALSE			FALSE					TRUE	Deleted from CPT
90471	Immunization	Immunization Admir	April 2021	19		AAFP, AAP	0.17	CMS Requ	February 2	XXX	0.17	0.31	NA	0.01	282357	FALSE			FALSE					TRUE	Maintain
90472	Immunization	Immunization Admir	April 2021	19		AAFP, AAP	0.15	CMS Requ	February 2	ZZZ	0.15	0.21	NA	0.01	22524	FALSE			FALSE					TRUE	Maintain
90473	Immunization	Immunization Admir	April 2021	19		AAFP, AAP	0.17	CMS Requ	NA	XXX	0.17	0.31	NA	0.01	3	FALSE			FALSE					TRUE	Maintain
90474	Immunization	Immunization Admir	April 2021	19		AAFP, AAP	0.15	CMS Requ	NA	ZZZ	0.15	0.21	NA	0.01	1	FALSE			FALSE					TRUE	Maintain
90785	Interactive cor	Psychotherapy for C	January 2020	37	October 2(	RUC	APA, APA (	Refer to Cl	CMS High	April 2013	ZZZ	0.33	0.09	0.04	0.01	408566	FALSE			TRUE	In October 2019, the Wor	October 2(	55	Complete	FALSE	Increase
90791	Psychiatric dia	Psychotherapy	April 2012	26		APA, APA (	3.00	CMS High	April 2013	XXX	3.84	1.20	0.50	0.14	917143	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90792	Psychiatric dia	Psychotherapy	April 2012	26		APA, APA (	3.25	CMS High	April 2013	XXX	4.16	1.47	0.75	0.15	586327	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90801	Psychiatric dia	RAW review	January 2012	30				Deleted fr	CMS High	September 2011						FALSE			TRUE	January 2012, the RAW re	February 2	93	Complete	TRUE	Deleted from CPT
90805	Individual psyc	RAW review	January 2012	30				Deleted fr	CMS High	September 2011						FALSE			TRUE	January 2012, the RAW re	February 2	93	Complete	TRUE	Deleted from CPT
90806	Individual psyc	RAW review	January 2012	30				Deleted fr	CMS High	September 2011						FALSE			TRUE	January 2012, the RAW re	February 2	93	Complete	TRUE	Deleted from CPT
90808	Individual psyc	RAW review	January 2012	30				Deleted fr	CMS High	September 2011						FALSE			TRUE	January 2012, the RAW re	February 2	93	Complete	TRUE	Deleted from CPT
90818	Individual psyc	RAW review	January 2012	30				Deleted fr	CMS High	September 2011						FALSE			TRUE	January 2012, the RAW re	February 2	93	Complete	TRUE	Deleted from CPT
90832	Psychotherapy	Psychotherapy	April 2012	26		APA, APA (	1.50	CMS High	April 2013	XXX	1.7	0.48	0.22	0.05	2306870	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90833	Psychotherapy	Psychotherapy	April 2012	26		APA, APA (	1.50	CMS High	April 2013	ZZZ	1.5	0.49	0.27	0.05	1401042	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90834	Psychotherapy	Psychotherapy	April 2012	26		APA, APA (	2.00	CMS High	April 2013	XXX	2.24	0.63	0.28	0.09	4939452	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90836	Psychotherapy	Psychotherapy	April 2012	26		APA, APA (	1.90	CMS High	April 2013	ZZZ	1.9	0.62	0.34	0.06	510888	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90837	Psychotherapy	Psychotherapy	April 2012	26		APA, APA (	3.00	CMS High	April 2013	XXX	3.31	0.93	0.42	0.13	6027217	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90838	Psychotherapy	Psychotherapy	April 2012	26		APA, APA (	2.50	CMS High	April 2013	ZZZ	2.5	0.82	0.46	0.10	100884	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90839	Psychotherapy	Psychotherapy for C	April 2013	35		APA, APA (	3.13	CMS High	April 2013	XXX	3.13	0.90	0.41	0.13	23040	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90840	Psychotherapy	Psychotherapy for C	April 2013	35		APA, APA (	1.50	CMS High	April 2013	ZZZ	1.5	0.42	0.19	0.05	6284	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90845	Psychoanalysis	Psychotherapy	October 2011				2.10	CMS High	April 2013	XXX	2.1	0.62	0.31	0.09	5591	FALSE			FALSE					TRUE	Increase
90846	Family psychot	Psychotherapy	April 2012	26		APA, APA (	2.40	CMS High	April 2013	XXX	2.4	0.35	0.33	0.09	21975	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90847	Family psychot	Psychotherapy	April 2012	26		APA, APA (	2.50	CMS High	April 2013	XXX	2.5	0.35	0.33	0.09	178166	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90853	Group psychot	Psychotherapy	April 2012	26		APA, APA (	0.59	CMS High	April 2013	XXX	0.59	0.18	0.08	0.02	906163	FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Maintain
90862	Pharmacologic	RAW review	January 2012	30				Deleted fr	CMS High	September 2011						FALSE			TRUE	January 2012, the RAW re	February 2	93	Complete	TRUE	Deleted from CPT
90863	Pharmacologic	Pharmacologic Mani	April 2013	40		APA (HCP/	0.48	CMS High	April 2013	XXX	0.48	0.23	0.19	0.04		FALSE			TRUE	CPT February 2012 - creat	February 2	93	Complete	TRUE	Increase
90868	Therapeutic repetitive transcranial		October 2020	23	October 2(	RAW		Review in	Contractor	January 2(	000	0	0.00	0.00	0.00	238754	FALSE			FALSE					FALSE	
90870	Electroconvuls	Electroconvulsive Th	April 2010	41		APA	2.50	Harvard Va	October 2(	000	2.5	2.49	0.51	0.09	126401	FALSE			FALSE					TRUE	Increase
90911	Biofeedback tr	Biofeedback Trainin	January 2019	15		ACOG, AU	Deleted fr		Negative I'	April 2017					28865	FALSE			TRUE	At the April 2018 meeting	Septembe	34	complete	TRUE	Deleted from CPT
90912	Biofeedback tr	Biofeedback Trainin	January 2019	15			0.90		Negative I'	Septembe	000	0.9	1.43	0.31	0.05		FALSE			TRUE	In January 2019, the RUC	February 2	EC-T Issue	complete	TRUE	Increase
90913	Biofeedback tr	Biofeedback Trainin	January 2019	15			0.50		Negative I'	Septembe	ZZZ	0.5	0.40	0.17	0.04		FALSE			TRUE	In January 2019, the RUC	February 2	EC-T Issue	complete	TRUE	Increase
90935	Hemodialysis p	Hemodialysis-Dialys	October 2009	30		RPA	1.48		Havard Va	October 2(	000	1.48	NA	0.53	0.09	1098691	FALSE			FALSE					TRUE	Increase
90937	Hemodialysis p	Hemodialysis-Dialys	October 2009	30		RPA	2.11		Havard Va	February 2	000	2.11	NA	0.78	0.13	51752	FALSE			FALSE					TRUE	Maintain
90945	Dialysis proce	Hemodialysis-Dialys	October 2009	30		RPA	1.56		Havard Va	February 2	000	1.56	NA	0.83	0.10	165382	FALSE			FALSE					TRUE	Increase
90947	Dialysis proce	Hemodialysis-Dialys	October 2009	30		RPA	2.52		Havard Va	February 2	000	2.52	NA	0.91	0.15	11769	FALSE			FALSE					TRUE	Increase
90951	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	23.92	8.88	8.88	1.55	17	FALSE			FALSE					TRUE	PE Only
90952	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	0	0.00	0.00	0.00	4	FALSE			FALSE					TRUE	PE Only
90953	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	0	0.00	0.00	0.00	1	FALSE			FALSE					TRUE	PE Only
90954	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	15.98	5.66	5.66	1.00	571	FALSE			FALSE					TRUE	PE Only
90955	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	10.32	4.37	4.37	0.62	57	FALSE			FALSE					TRUE	PE Only
90956	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	6.64	3.10	3.10	0.43	124	FALSE			FALSE					TRUE	PE Only
90957	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	15.46	6.19	6.19	0.96	1539	FALSE			FALSE					TRUE	PE Only
90958	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	9.87	4.23	4.23	0.62	393	FALSE			FALSE					TRUE	PE Only
90959	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	6.19	2.93	2.93	0.38	292	FALSE			FALSE					TRUE	PE Only
90960	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	6.77	3.20	3.20	0.42	2218361	FALSE			FALSE					TRUE	PE Only
90961	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	5.52	2.75	2.75	0.33	719245	FALSE			FALSE					TRUE	PE Only
90962	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	3.57	2.11	2.11	0.21	213048	FALSE			FALSE					TRUE	PE Only
90963	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	12.09	4.93	4.93	0.74	229	FALSE			FALSE					TRUE	PE Only
90964	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	10.25	4.37	4.37	0.64	934	FALSE			FALSE					TRUE	PE Only
90965	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	9.8	4.26	4.26	0.62	1343	FALSE			FALSE					TRUE	PE Only
90966	End-stage ren	End-Stage Renal Dis	April 2009	29		RPA		RUC Recor	CMS Requ	February 2	XXX	5.52	2.74	2.74	0.33	365733	FALSE			FALSE					TRUE	PE Only
91038	Esophageal fu	Gastroenterological	February 2010	23		AGA, ASGE		New PE In	CMS Requ	February 2	000	1.1	12.08	NA	0.05	4829	FALSE			FALSE					TRUE	PE Only
91110	Gastrointestin	Gastrointestinal Tra	January 2016	44		ACG, AGA,	2.49		CMS High	July 2015	XXX	2.49	22.79	NA	0.10	53131	FALSE			FALSE					TRUE	Decrease
91111	Gastrointestin	Gastrointestinal Tra	January 2016	44		ACG, AGA,	1.00		CMS High	July 2015	XXX	1	26.74	NA	0.05	146	FALSE			FALSE					TRUE	Maintain
91132	Electrogastrog	Electrogastrography	February 2010	24		AGA, ACG,		New PE In	CMS Request - Practi		XXX	0.52	11.72	NA	0.03	114	FALSE			FALSE					TRUE	PE Only
91133	Electrogastrog	Electrogastrography	February 2010	24		AGA, ACG,		New PE In	CMS Request - Practi		XXX	0.66	12.25	NA	0.03	14	FALSE			FALSE					TRUE	PE Only
92065	Orthoptic train	Orthoptic Training	April 2021	10		AAO, AOA	0.71		Harvard Va	October 2(	XXX	0.37	1.17	NA	0.02	32858	FALSE			TRUE	This service was identifie	February 2	35	Complete	TRUE	Increase
92081	Visual field exa	Visual Field Examina	April 2010	42		AAO, AOA	0.30		Harvard Va	October 2(	XXX	0.3	0.66	NA	0.02	92708	FALSE			FALSE					TRUE	Decrease
92082	Visual field exa	Visual Field Examina	April 2010	42		AAO, AOA	0.40		Harvard Va	October 2(	XXX	0.4	0.96	NA	0.02	122984	FALSE			FALSE					TRUE	Decrease
92083	Visual field exa	Visual Field Examina	April 2012	46		AAO, AOA	0.50		MPC List /	October 2(	XXX	0.5	1.32	NA	0.02	2969637	FALSE			FALSE					TRUE	Maintain
92100	Serial tonomet	Serial Tonometry	September 201	36		AAO, AOA	0.61		Harvard Va	April 2011	XXX	0.61	1.85	0.32	0.02	31551	FALSE			FALSE					TRUE	Decrease
92133	Scanning com	Computerized Scanr	April 2010	23		AAO, AOA	0.50		CMS Faste	October 2(	XXX	0.4	0.66	NA	0.02	2814680	FALSE			FALSE		October 2(	44		TRUE	Decrease
92134	Scanning com	Computerized Scanr	April 2010	23		AAO, AOA	0.50		CMS Faste	October 2(	XXX	0.45	0.72	NA	0.02	7509080	FALSE			FALSE		October 2(	44		TRUE	Decrease
92135	Deleted from (	Ophthalmic Diagnos	October 2009	31		AAO, AOA	Deleted fr		CMS Faste	October 2008							FALSE			TRUE	Revise to specify optic ne	October 2(	44	Code Delete	TRUE	Deleted from CPT
92136	Ophthalmic bi	Ophthalmic Biometr	April 2016	36		AAO	0.54		CMS Faste	October 2(	XXX	0.54	1.03	NA	0.02	1688098	FALSE			FALSE					TRUE	Maintain
92140	Provocative te	Glaucoma Provocati	April 2016	41		AAO, AOA	Deleted fr		Harvard Va	October 2015							FALSE			TRUE	The specialty societies no	May 2016	26	Complete	TRUE	Deleted from CPT
92201	Ophthalmosco	Ophthalmoscopy	April 2018	05		AAO, AOA	0.40		Negative I'	February 2	XXX	0.4	0.30	0.24	0.02		FALSE			FALSE		February 2	22		TRUE	Decrease
92202	Ophthalmosco	Ophthalmoscopy	April 2018	05		AAO, AOA	0.26		Negative I'	February 2	XXX	0.26	0.19	0.15	0.01		FALSE			FALSE		February 2	22		TRUE	Decrease

92225	Ophthalmosco	Ophthalmoscopy	April 2018	05			AAO, AOA	Deleted fr	Negative I'	April 2017						947451	FALSE			TRUE	A RUC member requeste	February 2	22	complete	TRUE	Deleted from CPT
92226	Ophthalmosco	Ophthalmoscopy	April 2018	05			AAO, AOA	Deleted fr	Negative I'	February 2018						2551942	FALSE			FALSE		February 2	22		TRUE	Deleted from CPT
92235	Fluorescein an	Ophthalmoscopic Ar	January 2016	21		RUC	AAO, ASRS	0.75	Harvard V	April 2011	XXX	0.75	2.65	NA	0.02	428183	FALSE			TRUE	In January 2015, the Joint	October 2(	55	Complete	TRUE	Decrease
92240	Indocyanine-g	Ophthalmoscopic Ar	January 2016	21		RUC	AAO, ASRS	0.80	Codes Rep	January 2C	XXX	0.8	5.07	NA	0.06	10668	FALSE			TRUE	In January 2015, the Joint	October 2(	55	Complete	TRUE	Decrease
92242	Fluorescein an	Ophthalmoscopic Ar	January 2016	21		RUC	AAO, ASRS	0.95	Codes Rep	October 2(	XXX	0.95	6.37	NA	0.03	37989	FALSE			TRUE	In January 2015, the Joint	October 2(	55	Complete	TRUE	Decrease
92250	Fundus photog	Fundus Photography	January 2016	45			AAO, ASRS	0.40	MPC List /	October 2(	XXX	0.4	0.72	NA	0.02	3490129	FALSE			FALSE					TRUE	Decrease
92270	Electro-oculog	Electro-oculography	October 2017	19			AAO-HNS	CPT Assist	High Volur	February 2	XXX	0.81	2.17	NA	0.02	2435	TRUE	Aug 2008 a	Yes	TRUE	The specialties indicated	February 2	87	Complete	TRUE	Maintain
92273	Electroretinog	Electroretinography	January 2021	29	January 2C	RAW		Review ac	CMS High	Septembe	XXX	0.69	3.11	NA	0.03	68699	FALSE			FALSE					TRUE	Decrease
92274	Electroretinog	Electroretinography	January 2021	29	January 2C	RAW		Review ac	CMS High	Septembe	XXX	0.61	1.97	NA	0.02	6340	FALSE			FALSE					TRUE	Decrease
92275	Electroretinog	Electroretinography	January 2018	17			AAO, ASRS	Deleted fr	CMS High	July 2015							FALSE			TRUE	In January 2016, the spec	June 2017	24	yes	TRUE	Deleted from CPT
92284	Dark adaptatic	Dark Adaption Eye E	April 2021	20	October 2(	RAW	AAO, AOA	0.14. Revie	Harvard V	October 2(	XXX	0.24	1.45	NA	0.03	32615	FALSE			TRUE	In April 2021, the RUC rec	May 2021	EC-M	complete	TRUE	Decrease
92285	External ocula	Ocular Photography	October 2009	32			AAO, AOA	0.05 and n	CMS Faste	October 2(	XXX	0.05	0.60	NA	0.02	406118	FALSE			TRUE	The specialty noted that ι	February 2010		Complete	TRUE	Decrease
92286	Anterior segm	Anterior Segment In	April 2012	28			AAO, AOA	0.40	Harvard V	April 2011	XXX	0.4	0.72	NA	0.02	115474	FALSE			TRUE	The specialty societies in	October 2(	20	Complete	TRUE	Decrease
92287	Anterior segm	Anterior Segment In	April 2021	21			AAO, ASRS	0.40	Harvard Valued - Util		XXX	0.81	4.21	NA	0.03	7182	TRUE	Mar 2013	Yes	TRUE	The specialty societies in	October 2(	20	Complete	TRUE	Decrease
92504	Binocular micr	Binocular Microscop	April 2010	43			AAO-HNS	0.18	Harvard V	October 2(	XXX	0.18	0.67	0.08	0.01	239518	FALSE			FALSE					TRUE	Maintain
92506	Evaluation of s	Speech Language Pa	February 2010	28			ASHA	Deleted fr	CMS Request/Speech Language Pathology Request								FALSE			TRUE	The specialty society afte	October 2(	28	Complete	TRUE	Deleted from CPT
92507	Treatment of s	Speech Language Pa	January 2016	54			ASHA	1.30 work	CMS Requ	October 2(	XXX	1.3	0.89	NA	0.05	350653	FALSE			FALSE					TRUE	Decrease
92508	Treatment of s	Speech Language Pa	February 2010	28			ASHA	0.43 work	CMS Request/Speech		XXX	0.33	0.35	NA	0.01	4438	FALSE			FALSE					TRUE	Decrease
92521	Evaluation of s	Speech Evaluation	January 2013	32			ASHA	1.75	CMS Request/Speech		XXX	2.24	1.59	NA	0.09	197	FALSE			FALSE		October 2(	28	Complete	TRUE	Increase
92522	Evaluation of s	Speech Evaluation	January 2013	32			ASHA	1.50	CMS Request/Speech		XXX	1.92	1.26	NA	0.10	3374	FALSE			FALSE		October 2(	28	Complete	TRUE	Increase
92523	Evaluation of s	Speech Evaluation	January 2013	32			ASHA	3.36	CMS Request/Speech		XXX	3.84	2.75	NA	0.15	19962	FALSE			FALSE		October 2(	28	Complete	TRUE	Increase
92524	Behavioral anc	Speech Evaluation	January 2013	32			ASHA	1.75	CMS Request/Speech		XXX	1.92	1.20	NA	0.09	18441	FALSE			FALSE		October 2(	28	Complete	TRUE	Increase
92526	Treatment of s	Speech Language Pa	October 2020	23			ASHA, AAC	Maintain	CMS Requ	NA	XXX	1.34	1.09	NA	0.05	133424	FALSE			FALSE					TRUE	Decrease
92537	Caloric vestibu	Vestibular Caloric Irr	January 2015	18			AAA, AAN,	0.80	CMS-Othe	October 2(	XXX	0.6	0.60	NA	0.02	68931	FALSE			FALSE		October 2(	54	Complete	TRUE	Increase
92538	Caloric vestibu	Vestibular Caloric Irr	January 2015	18			AAA, AAN,	0.55	CMS-Othe	October 2(	XXX	0.3	0.34	NA	0.02	6794	FALSE			FALSE		October 2(	54	Complete	TRUE	Increase
92540	Basic vestibula	EOG VNG	April 2014	24			AAN, ASH/	1.50	Codes Reported Toge		XXX	1.5	1.66	NA	0.05	89363	FALSE			FALSE					TRUE	Decrease
92541	Spontaneous r	EOG VNG	April 2014	24			AAN, ASH/	0.40	Codes Rep	February 2	XXX	0.4	0.32	NA	0.02	13573	FALSE			TRUE	Referred to the CPT Edito	February 2	54	Complete	TRUE	Maintain
92542	Positional nyst	EOG VNG	April 2014	24			AAN, ASH/	0.48	Codes Rep	February 2	XXX	0.48	0.36	NA	0.02	19332	FALSE			TRUE	Referred to the CPT Edito	February 2	54	Complete	TRUE	Increase
92543	Caloric vestibu	Vestibular Caloric Irr	January 2015	18			AAA, AAN,	Deleted fr	Codes Rep	February 2008							FALSE			TRUE	The RUC discussed the cc	October 2(	54	Complete	TRUE	Deleted from CPT
92544	Optokinetic ny	EOG VNG	April 2014	24			AAN, ASH/	0.27	Codes Rep	February 2	XXX	0.27	0.24	NA	0.02	2943	FALSE			TRUE	Referred to the CPT Edito	February 2	54	Complete	TRUE	Increase
92545	Oscillating trac	EOG VNG	April 2014	24			AAN, ASH/	0.25	Codes Rep	February 2	XXX	0.25	0.22	NA	0.02	3622	FALSE			TRUE	Referred to the CPT Edito	February 2	54	Complete	TRUE	Increase
92546	Sinusoidal vert	EOG VNG	April 2014	24				Editorial cl	CMS-Othe	February 2	XXX	0.29	3.16	NA	0.03	43026	FALSE			TRUE	Referred to the CPT Edito	February 2	87	Complete	TRUE	Maintain
92547	Use of vertical	EOG VNG	April 2014	24				Editorial cl	CMS-Othe	February 2	ZZZ	0	0.29	NA	0.00	26526	FALSE			TRUE	Referred to the CPT Edito	February 2	87	Complete	TRUE	Maintain
92548	Computerized	Computerized Dyna	January 2019	16			AAA, AAN,	0.76	CMS-Othe	February 2	XXX	0.67	0.75	NA	0.03	51157	FALSE			TRUE	In 2014 the RUC referred	Septembe	35	complete	TRUE	Increase
92549	Computerized	Computerized Dyna	January 2019	16		RUC		0.96	CMS-Othe	Septembe	XXX	0.87	0.94	NA	0.05		FALSE			FALSE		Septembe	35	complete	TRUE	Increase
92550	Tympanometr	Bundled Audiology T	April 2009	22			ASHA, AAC	0.35	Codes Reported Toge		XXX	0.35	0.28	NA	0.02	231898	FALSE			FALSE					TRUE	Decrease
92557	Comprehensiv	Bundled Audiology T	April 2009	22			ASHA, AAC	0.60 work	Codes Rep	February 2	XXX	0.6	0.48	0.31	0.04	1255685	FALSE			TRUE	Referred to the CPT Edito	February 2	54	Complete	TRUE	Decrease
92558	Evoked otoacc	Otoacoustic Emissio	April 2011	35			ASHA	0.17	CMS Faste	February 2	XXX	0.17	0.10	0.07	0.01		FALSE			FALSE		February 2011			TRUE	Increase
92567	Tympanometr	Bundled Audiology T	April 2009	22			ASHA, AAC	0.20 work	Codes Rep	February 2	XXX	0.2	0.27	0.10	0.01	922916	FALSE			TRUE	Referred to the CPT Edito	February 2	54	Complete	TRUE	Decrease
92568	Acoustic reflex	Bundled Audiology T	April 2009	22			ASHA, AAC	0.29 work	Codes Rep	February 2	XXX	0.29	0.14	0.13	0.02	5046	FALSE			TRUE	Referred to the CPT Edito	February 2	54	Complete	TRUE	Decrease
92569	Deleted from (	Bundled Audiology T	April 2009	22			ASHA, AAC	Deleted fr	Codes Rep	February 2008							FALSE			TRUE	Referred to the CPT Edito	February 2	54	Code Delete	TRUE	Deleted from CPT
92570	Acoustic immit	Bundled Audiology T	October 2015	21			ASHA, AAC	0.55	Codes Reported Toge		XXX	0.55	0.38	0.28	0.04	38849	FALSE			FALSE					TRUE	Decrease
92584	Electrocochlec	Auditory Evoked Pot	April 2019	06			AAA, AAO-	1.00	CMS-Othe	February 2	XXX	1	2.43	NA	0.05	11016	FALSE			FALSE					TRUE	Increase
92585	Auditory evok	Auditory Evoked Pot	April 2019	06			AAA, AAO-	Deleted fr	CMS-Othe	October 2017						34565	FALSE			TRUE	In October 2017, the RAW	February 2	19	complete	TRUE	Deleted from CPT
92586	Auditory evok	Auditory Evoked Pot	April 2019	06			AAA, AAO-	Deleted fr	CMS-Othe	February 2019						1425	FALSE			FALSE		February 2	19	complete	TRUE	Deleted from CPT
92587	Distortion pro	Otoacoustic Emissio	April 2011	35			ASHA	0.45	CMS Faste	October 2(	XXX	0.35	0.28	NA	0.02	58068	FALSE			TRUE	The specialty noted that t	October 2(	41	Complete	TRUE	Increase
92588	Distortion pro	Otoacoustic Emissio	April 2011	35			ASHA	0.60	CMS Fastest Growing		XXX	0.55	0.42	NA	0.02	85077	FALSE			FALSE		February 2011			TRUE	Increase
92597	Evaluation for	Speech Language Pa	February 2009	30			ASHA	1.48 work	CMS Requ	NA	XXX	1.26	0.77	NA	0.05	2839	FALSE			FALSE					TRUE	Decrease
92605	Evaluation for	Eval of Rx for Non-S	April 2011	35			ASHA	1.75	CMS Request/Speech		XXX	1.75	0.85	0.68	0.14		FALSE			TRUE	The specialty society afte	February 2	58	Complete	TRUE	Increase
92606	Therapeutic se	Speech Language Pa	February 2010	28			ASHA	1.40 work	CMS Request/Speech		XXX	1.4	0.91	0.54	0.13		FALSE			FALSE					TRUE	Decrease
92607	Evaluation for	Speech Language Pa	February 2010	28			ASHA	1.85 work	CMS Request/Speech		XXX	1.85	1.75	NA	0.06	544	FALSE			FALSE					TRUE	Decrease
92608	Evaluation for	Speech Language Pa	February 2010	28			ASHA	0.70 work	CMS Request/Speech		ZZZ	0.7	0.73	NA	0.04	220	FALSE			FALSE					TRUE	Decrease
92609	Therapeutic se	Speech Language Pa	February 2010	28			ASHA	1.50 work	CMS Request/Speech		XXX	1.5	1.51	NA	0.05	14910	FALSE			FALSE					TRUE	Decrease
92610	Evaluation of c	Speech Language Pa	October 2020	23			ASHA, AAC	Maintain	CMS Requ	NA	XXX	1.3	1.13	0.68	0.05	22897	FALSE			FALSE					TRUE	Decrease
92611	Motion fluoros	Speech Language Pa	April 2009	39			ASHA	1.34 work	CMS Requ	NA	XXX	1.34	1.26	NA	0.09	9673	FALSE			FALSE					TRUE	Decrease
92618	Evaluation for	Eval of Rx for Non-S	April 2011	35			ASHA	0.65	CMS Request/Speech		ZZZ	0.65	0.26	0.25	0.05		FALSE			FALSE		February 2	58		TRUE	Increase
92620	Evaluation of c	Audiology Services	October 2008	17			ASHA, AAC	1.50	CMS Requ	NA	XXX	1.5	1.15	0.79	0.05	818	FALSE			FALSE					TRUE	Decrease
92621	Evaluation of c	Audiology Services	October 2008	17			ASHA, AAC	0.35	CMS Requ	NA	ZZZ	0.35	0.30	0.19	0.01	43	FALSE			FALSE					TRUE	Decrease
92625	Assessment of	Audiology Services	October 2008	17			ASHA, AAC	1.15	CMS Requ	NA	XXX	1.15	0.83	0.60	0.05	9371	FALSE			FALSE					TRUE	Decrease
92626	Evaluation of a	Audiology Services	October 2018	30			AAA, ASH/	1.40	CMS Requ	NA	XXX	1.4	1.17	0.74	0.05	29623	TRUE	July 2014	Yes	TRUE	In October 2016, this serv	May 2018	34	Yes	TRUE	Decrease
92627	Evaluation of a	Audiology Services	October 2018	30			ASHA, AAC	0.33	CMS Requ	NA	ZZZ	0.33	0.28	0.18	0.01	7594	FALSE			FALSE					TRUE	Decrease
92640	Diagnostic ana	Audiology Services	October 2008	17			ASHA, AAC	1.76	CMS Requ	NA	XXX	1.76	1.50	0.95	0.05	11	FALSE			FALSE					TRUE	Decrease
92650	Auditory evok	Auditory Evoked Pot	April 2019	06			AAA, AAO-	0.25	CMS-Othe	February 2	XXX	0.25	0.56	NA	0.02		FALSE			FALSE		February 2	19	complete	TRUE	Decrease
92651	Auditory evok	Auditory Evoked Pot	April 2019	06			AAA, AAO-	1.00	CMS-Othe	February 2	XXX	1	1.57	NA	0.05		FALSE			FALSE		February 2	19	complete	TRUE	Increase
92652	Auditory evok	Auditory Evoked Pot	April 2019	06			AAA, AAO-	1.50	CMS-Othe	February 2	XXX	1.5	1.84	NA	0.09		FALSE			FALSE		February 2	19	complete	TRUE	Increase
92653	Auditory evok	Auditory Evoked Pot	April 2019	06			AAA, AAN,	1.05	CMS-Othe	February 2	XXX	1.05	1.41	NA	0.05		FALSE			FALSE		February 2	19	complete	TRUE	Increase
92920	Percutaneous	Percutaneous Coron	January 2012	10			ACC	9.00	MPC List	October 2(	000	9.85	NA	3.43	2.17	24084	FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92921	Percutaneous	Percutaneous Coron	January 2012	10			ACC	4.00	MPC List	October 2(	ZZZ	0	0.00	0.00	0.00		FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92924	Percutaneous	Percutaneous Coron	January 2012	10			ACC	11.00	MPC List	October 2(	000	11.74	NA	4.09	2.59	2282	FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92925	Percutaneous	Percutaneous Coron	January 2012	10			ACC	5.00	MPC List	October 2(	ZZZ	0	0.00	0.00	0.00		FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92928	Percutaneous	Percutaneous Coron	January 2012	10			ACC	10.49	MPC List	October 2(	000	10.96	NA	3.81	2.42	254826	FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92929	Percutaneous	Percutaneous Coron	January 2012	10			ACC	4.44	MPC List	October 2(	ZZZ	0	0.00	0.00	0.00		FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92933	Percutaneous	Percutaneous Coron	January 2012	10			ACC	12.32	MPC List	October 2(	000	12.29	NA	4.27	2.74	19416	FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92934	Percutaneous	Percutaneous Coron	January 2012	10			ACC	5.50	MPC List	October 2(	ZZZ	0	0.00	0.00	0.00		FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92937	Percutaneous	Percutaneous Coron	January 2012	10			ACC	10.49	MPC List	October 2(	000	10.95	NA	3.80	2.42	18930	FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92938	Percutaneous	Percutaneous Coron	January 2012	10			ACC	6.00	MPC List	October 2(	ZZZ	0	0.00	0.00	0.00		FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92941	Percutaneous	Percutaneous Coron	January 2012	10			ACC	12.32	MPC List	October 2(	000	12.31	NA	4.28	2.72	41108	FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92943	Percutaneous	Percutaneous Coron	January 2012	10			ACC	12.32	MPC List	October 2(	000	12.31	NA	4.28	2.74	9129	FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92944	Percutaneous	Percutaneous Coron	January 2012	10			ACC	6.00	MPC List	October 2(	ZZZ	0	0.00	0.00	0.00		FALSE			TRUE		October 2(	21	Complete	TRUE	Decrease
92960	Cardioversion,	Cardioversion	October 2010	19			ACC	2.25	Harvard V	October 2(	000	2	2.49	1.01	0.15	201622	FALSE			FALSE					TRUE	Maintain

92973	Percutaneous	RAW	October 2017	19			Remove fr	High Volur	April 2013	ZZZ	3.28	NA	1.14	0.74	2130	FALSE			FALSE					TRUE	Maintain
92980	Transcatheter	Percutaneous Coron	January 2012	10		ACC	Deleted fr	MPC List	October 2010							FALSE			TRUE	Specialty society is planni	October 2(	21	Deleted fro	TRUE	Deleted from CPT
92981	Transcatheter	Percutaneous Coron	January 2012	10		ACC	Deleted fr	MPC List	October 2010							FALSE			TRUE	Specialty society is planni	October 2(	21	Deleted fro	TRUE	Deleted from CPT
92982	Percutaneous	Percutaneous Coron	January 2012	10		ACC	Deleted fr	MPC List /	October 2010							FALSE			TRUE	Specialty society is planni	October 2(	21	Deleted fro	TRUE	Deleted from CPT
92984	Percutaneous	Percutaneous Coron	January 2012	10		ACC	Deleted fr	MPC List	October 2010							FALSE			TRUE	Specialty society is planni	October 2(	21	Deleted fro	TRUE	Deleted from CPT
92986	Percutaneous	Valvuloplasty	October 2008	26		ACC	Deleted fr	CMS Faste	October 2(	090	22.6	NA	10.90	4.97	2857	FALSE			FALSE					TRUE	Remove from Screen
92992	Atrial septecto	Atrial Septostomy	January 2020	13			Deleted fr	CMS Requ	October 2018						76	FALSE			TRUE	In January 2019, the RUC	Septembe	16	yes	TRUE	Deleted from CPT
92993	Atrial septecto	Atrial Septostomy	January 2020	13			Deleted fr	CMS Requ	October 2018						1	FALSE			TRUE	In January 2019, the RUC	Septembe	16	yes	TRUE	Deleted from CPT
92995	Percutaneous	Percutaneous Coron	January 2012	10		ACC	Deleted fr	MPC List	October 2010							FALSE			TRUE	Specialty society is planni	October 2(	21	Deleted fro	TRUE	Deleted from CPT
92996	Percutaneous	Percutaneous Coron	January 2012	10		ACC	Deleted fr	MPC List	October 2010							FALSE			TRUE	Specialty society is planni	October 2(	21	Deleted fro	TRUE	Deleted from CPT
93000	Electrocardiog	Complete Electrocar	April 2019	20		ACC	0.17	CMS High	Septembe	XXX	0.17	0.24	NA	0.02	11883535	FALSE			FALSE					TRUE	Maintain
93005	Electrocardiog	Complete Electrocar	April 2019	20		ACC	0.00	High Volur	February 2	XXX	0	0.18	NA	0.01	460887	FALSE			FALSE					TRUE	PE Only
93010	Electrocardiog	Complete Electrocar	April 2019	20		ACC	0.17	MPC List /	October 2(	XXX	0.17	0.06	0.06	0.01	18866949	FALSE			FALSE					TRUE	Maintain
93012	Deleted from (	External Cardiovascı	April 2010	25		ACC	Deleted fr	Harvard V	October 2009							FALSE			FALSE		February 2	57		TRUE	Deleted from CPT
93014	Deleted from (	External Cardiovascı	April 2010	25		ACC	Deleted fr	Harvard V	October 2009							FALSE			FALSE		February 2	57		TRUE	Deleted from CPT
93015	Cardiovascular	Cardiovascular Stres	April 2012	47		ACC	0.75. CPT /	Codes Rep	February 2	XXX	0.75	1.26	NA	0.05	999644	TRUE	Jan 2010	Yes	TRUE	The RUC accepted the sp	October 2(	42	Complete	TRUE	Maintain
93016	Cardiovascular	Cardiovascular Stres	April 2012	47		ACC	0.45	Codes Rep	February 2	XXX	0.45	0.16	0.16	0.02	1047732	FALSE			FALSE					TRUE	Maintain
93017	Cardiovascular	Cardiovascular Stres	April 2010	45		ACC	New PE in	High Volur	February 2	XXX	0	0.99	NA	0.02	96453	FALSE			FALSE					TRUE	PE Only
93018	Cardiovascular	Cardiovascular Stres	April 2012	47		ACC	0.30	Codes Rep	February 2	XXX	0.3	0.11	0.11	0.01	1241516	TRUE	Jan 2010	Yes	TRUE	The RUC accepted the sp	October 2(	42	Complete	TRUE	Maintain
93025	Microvolt t-wa	Microvolt T-Wave A	October 2008	18		ACC	New PE In	CMS Requ	NA	XXX	0.75	3.15	NA	0.04	213	FALSE			FALSE					TRUE	PE Only
93040	Rhythm ecg, 1	Rhythm EKG	October 2009	34		ACC	0.15	Havard Va	February 2	XXX	0.15	0.20	NA	0.02	108714	FALSE			FALSE					TRUE	Decrease
93041	Rhythm ecg, 1	Rhythm EKG	October 2009	34		ACC	0.00 (PE o	Havard Va	February 2	XXX	0	0.16	NA	0.01	12914	FALSE			FALSE					TRUE	Maintain
93042	Rhythm ecg, 1	Rhythm EKG	October 2009	34		ACC, ACEP	0.15	Havard Va	October 2(	XXX	0.15	0.04	0.04	0.01	362235	FALSE			FALSE					TRUE	Decrease
93224	External electr	External Cardiovascı	April 2010	25		ACC	0.52	Harvard V	October 2(	XXX	0.39	1.89	NA	0.03	284557	FALSE			TRUE	The ACC and the Heart Rl	February 2	57	Revised	TRUE	Maintain
93225	External electr	External Cardiovascı	April 2010	25		ACC	N/A no ph	Harvard V	October 2(	XXX	0	0.57	NA	0.01	110328	FALSE			FALSE		February 2	57		TRUE	Maintain
93226	External electr	External Cardiovascı	April 2010	25		ACC	N/A no ph	Harvard V	October 2(	XXX	0	1.18	NA	0.01	154751	FALSE			FALSE		February 2	57		TRUE	Maintain
93227	External electr	External Cardiovascı	April 2010	25		ACC	0.52	Harvard V	October 2(	XXX	0.39	0.14	0.14	0.01	344162	FALSE			TRUE	The ACC and the Heart Rl	Feburary 2	57	Revised	TRUE	Maintain
93228	External mobil	External Cardiovascı	October 2020	20		ACC, HRS	0.52	Harvard V	October 2(	XXX	0.52	0.19	0.19	0.04	186123	FALSE			FALSE					TRUE	Maintain
93229	External mobil	External Cardiovascı	October 2020	20		ACC, HRS	PE Only	Harvard V	October 2(	XXX	0	20.46	NA	0.09	271792	FALSE			FALSE					TRUE	PE Only
93230	Deleted from (	Cardiac Device Moni	April 2009	31		ACC	Deleted fr	CMS Requ	NA							FALSE			TRUE	CMS stated that 93230 ar	February 2	57	Deleted	TRUE	Deleted from CPT
93231	Deleted from (	External Cardiovascı	April 2010	25			Deleted fr	Harvard V	October 2009							FALSE			FALSE		February 2	57		TRUE	Deleted from CPT
93232	Deleted from (	External Cardiovascı	April 2010	25			Deleted fr	Harvard V	October 2009							FALSE			FALSE		February 2	57		TRUE	Deleted from CPT
93233	Deleted from (	Cardiac Device Moni	April 2009	31		ACC	Deleted fr	CMS Requ	NA							FALSE			TRUE	CMS stated that 93230 ar	February 2	57	Deleted	TRUE	Deleted from CPT
93235	Deleted from (	External Cardiovascı	April 2010	25			Deleted fr	Harvard V	October 2009							FALSE			FALSE		February 2	57		TRUE	Deleted from CPT
93236	Deleted from (	Cardiovascular Stres	April 2009	38		ACC	Deleted fr	Harvard V	February 2008							FALSE			TRUE	In February 2008 the Wo	February 2	57	Deleted	TRUE	Deleted from CPT
93237	Deleted from (	Wearable Cardiac D	February 2010	31		ACC	Deleted fr	Harvard V	October 2009							FALSE			TRUE	The ACC and the Heart Rl	February 2	57	Complete	TRUE	Deleted from CPT
93268	External patier	External Cardiovascı	April 2010	25		ACC	0.52	Harvard V	October 2(	XXX	0.52	5.22	NA	0.04	11689	FALSE			FALSE		February 2	57		TRUE	Maintain
93270	External patier	External Cardiovascı	April 2010	25		ACC	New PE in	Harvard V	October 2(	XXX	0	0.25	NA	0.01	39075	FALSE			FALSE		February 2	57		TRUE	PE Only
93271	External patier	External Cardiovascı	April 2010	25		ACC	New PE in	Harvard V	October 2(	XXX	0	4.79	NA	0.01	54627	FALSE			FALSE		February 2	57		TRUE	PE Only
93272	External patier	External Cardiovascı	April 2010	25		ACC	0.52	Harvard V	October 2(	XXX	0.52	0.18	0.18	0.02	104829	FALSE			FALSE		February 2	57		TRUE	Maintain
93279	Programming (	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.65	CMS High	July 2015	XXX	0.65	1.25	NA	0.03	152741	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93280	Programming (	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.77	CMS High	July 2015	XXX	0.77	1.47	NA	0.05	986249	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93281	Programming (	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.85	CMS High	July 2015	XXX	0.85	1.54	NA	0.05	73701	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Decrease
93282	Programming (	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.85	CMS High	July 2015	XXX	0.85	1.42	NA	0.05	115690	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93283	Programming (	Cardiac Electrophysi	October 2016	25		ACC, HRS	1.15	CMS High	July 2015	XXX	1.15	1.64	NA	0.05	214401	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93284	Programming (	Cardiac Electrophysi	October 2016	25		ACC, HRS	1.25	CMS High	July 2015	XXX	1.25	1.77	NA	0.05	246603	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93285	Programming (	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.52	CMS High	July 2015	XXX	0.52	1.18	NA	0.03	40620	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93286	Peri-procedura	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.30	CMS High	July 2015	XXX	0.3	1.00	NA	0.02	20480	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93287	Peri-procedura	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.45	CMS High	July 2015	XXX	0.45	1.06	NA	0.03	12854	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93288	Interrogation (	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.43	CMS High	July 2015	XXX	0.43	1.15	NA	0.02	242876	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93289	Interrogation (	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.75	CMS High	July 2015	XXX	0.75	1.29	NA	0.05	97500	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Decrease
93290	Interrogation (	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.43	CMS High	July 2015	XXX	0.43	1.07	NA	0.03	118819	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93291	Interrogation (	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.37	CMS High	July 2015	XXX	0.37	1.02	NA	0.02	68111	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Decrease
93292	Interrogation (	Cardiac Electrophysi	October 2016	25		ACC, HRS	0.43	CMS High	July 2015	XXX	0.43	0.98	NA	0.03	1142	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Maintain
93293	Transtelephon	Cardiac Electrophysi	January 2017	23		ACC, HRS	0.31	CMS High	July 2015	XXX	0.31	1.15	NA	0.02	50828	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	Decrease
93294	Interrogation (	Cardiac Electrophysi	January 2017	23		ACC, HRS	0.60	CMS High	July 2015	XXX	0.6	0.24	0.24	0.04	1162316	FALSE			FALSE					TRUE	Decrease
93295	Interrogation (	Cardiac Electrophysi	January 2017	23		ACC, HRS	0.74	CMS High	July 2015	XXX	0.74	0.30	0.30	0.05	618312	FALSE			FALSE					TRUE	Decrease
93296	Interrogation (	Cardiac Electrophysi	October 2016	25		ACC, HRS	New PE in	CMS High	July 2015	XXX	0	0.73	NA	0.01	1298857	FALSE			TRUE	In the NPRM for 2016 CM	February 2	Advisory C	yes	TRUE	PE Only
93297	Interrogation (	Cardiac Electrophysi	January 2017	23		ACC, HRS	0.52	CMS High	July 2015	XXX	0.52	0.21	0.21	0.04	436176	FALSE			FALSE					TRUE	Maintain
93298	Interrogation (	Cardiac Electrophysi	January 2017	23		ACC, HRS	0.52	CMS High	July 2015	XXX	0.52	0.21	0.21	0.04	718193	FALSE			FALSE					TRUE	Maintain
93299	Interrogation (	Cardiac Electrophysi	October 2018	22		ACC, HRS	Deleted fr	CMS High	July 2015						790455	FALSE			TRUE	In October 2018, the RUC	February 2	20	complete	TRUE	Deleted from CPT
93306	Echocardiogra	Complete Transthor	April 2019	21		ACC, ASE	1.46	CMS High	July 2015	XXX	1.46	4.43	NA	0.07	7396555	FALSE			FALSE					TRUE	Decrease
93307	Echocardiogra	Transthoracic Echoc	April 2016	42		ACC	0.92	CMS Requ	NA	XXX	0.92	3.23	NA	0.06	26672	FALSE			FALSE					TRUE	Maintain
93308	Echocardiogra	Transthoracic Echoc	April 2016	42		ACC	0.53	CMS Faste	October 2(	XXX	0.53	2.39	NA	0.03	435885	FALSE			FALSE					TRUE	Maintain
93320	Doppler echoc	Doppler Echocardio	January 2014	30		ACC	0.38	CMS Requ	February 2	ZZZ	0.38	1.16	NA	0.02	365942	FALSE			FALSE					TRUE	Maintain
93321	Doppler echoc	Doppler Echocardio	January 2014	30		ACC	0.15	CMS-Othe	October 2(	ZZZ	0.15	0.62	NA	0.01	239405	FALSE			FALSE					TRUE	Maintain
93325	Doppler echoc	Doppler Echocardio	January 2014	30		ACC	0.07	CMS Requ	February 2	ZZZ	0.07	0.66	NA	0.00	606488	FALSE			FALSE					TRUE	Maintain
93350	Echocardiogra	Stress Transthoracic	October 2016	26	RUC	ACC, ASE	1.46; CPT /	Other - Ide	April 2008	XXX	1.46	4.11	NA	0.07	95788	TRUE	Jan 2010	Yes	TRUE	The RUC accepted the sp	October 2(	42	Complete	TRUE	Decrease
93351	Echocardiogra	Stress Transthoracic	October 2016	26	RUC	ACC, ASE	1.75	CMS High	July 2015	XXX	1.75	5.13	NA	0.09	241940	FALSE			FALSE					TRUE	Maintain
93451	Right heart cat	Diagnostic Cardiac C	April 2018	33		ACC	Remove fr	Codes Reported Toge		000	2.47	23.82	NA	0.48	44232	FALSE			FALSE		October 2(	13		TRUE	Decrease
93452	Left heart cath	Diagnostic Cardiac C	April 2011	28		ACC	4.32	Codes Reported Toge		000	4.5	22.80	NA	0.84	3594	FALSE			FALSE		October 2(	13		TRUE	Decrease
93453	Combined righ	Diagnostic Cardiac C	April 2011	28		ACC	5.98	Codes Reported Toge		000	5.99	28.76	NA	1.16	2368	FALSE			FALSE		October 2(	13		TRUE	Decrease
93454	Catheter place	Diagnostic Cardiac C	April 2011	28		ACC	4.95	Codes Reported Toge		000	4.54	22.77	NA	0.88	127375	FALSE			FALSE		October 2(	13		TRUE	Decrease
93455	Catheter place	Diagnostic Cardiac C	April 2011	28		ACC	6.15	Codes Reported Toge		000	5.29	25.34	NA	1.03	27649	FALSE			FALSE		October 2(	13		TRUE	Decrease
93456	Catheter place	Diagnostic Cardiac C	April 2018	33		ACC	Remove fr	Codes Reported Toge		000	5.9	28.29	NA	1.14	19829	FALSE			FALSE		October 2(	13		TRUE	Decrease
93457	Catheter place	Diagnostic Cardiac C	April 2011	28		ACC	7.66	Codes Reported Toge		000	6.64	30.82	NA	1.30	3711	FALSE			FALSE		October 2(	13		TRUE	Decrease
93458	Catheter place	Diagnostic Cardiac C	April 2011	28		ACC	6.51	Codes Reported Toge		000	5.6	25.90	NA	1.07	507961	FALSE			FALSE		October 2(	13		TRUE	Decrease
93459	Catheter place	Diagnostic Cardiac C	April 2011	28		ACC	7.34	Codes Reported Toge		000	6.35	27.63	NA	1.24	90436	FALSE			FALSE		October 2(	13		TRUE	Decrease
93460	Catheter place	Diagnostic Cardiac C	April 2011	28		ACC	7.88	Codes Reported Toge		000	7.1	30.59	NA	1.39	89701	FALSE			FALSE		October 2(	13		TRUE	Decrease
93461	Catheter place	Diagnostic Cardiac C	April 2011	28		ACC	9.00	Codes Reported Toge		000	7.85	33.97	NA	1.51	14051	FALSE			FALSE		October 2(	13		TRUE	Decrease

93462	Left heart cath	Diagnostic Cardiac C	April 2011	28		ACC	3.73	Codes Reported Toge	ZZZ	3.73	1.60	1.60	0.82	6479	FALSE		FALSE		October 2(	13		TRUE	Decrease
93463	Pharmacologic	Diagnostic Cardiac C	April 2011	28		ACC	2.00	Codes Reported Toge	ZZZ	2	0.70	0.70	0.15	6287	FALSE		FALSE		October 2(	13		TRUE	Decrease
93464	Physiologic ex	Diagnostic Cardiac C	April 2011	28		ACC	1.80	Codes Reported Toge	ZZZ	1.8	5.08	NA	0.10	1054	FALSE		FALSE		October 2(	13		TRUE	Decrease
93501	Deleted from (	Cardiac Catheterizat	April 2010	26		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93503	Insertion and p	Insertion of Cathete	April 2018	33		ACR, ASA	2.00	CMS High	July 2015	000	2	NA	0.38	0.17	71386	FALSE	FALSE					TRUE	Decrease
93508	Deleted from (	Cardiac Catheterizat	April 2010	26		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93510	Deleted from (	Cardiac Catheterizat	February 2009	31		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93511	Deleted from (	Cardiac Catheterizat	April 2010	26		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93514	Deleted from (	Cardiac Catheterizat	April 2010	26		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93524	Deleted from (	Cardiac Catheterizat	April 2010	26		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93526	Deleted from (	Cardiac Catheterizat	February 2008	S		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93527	Deleted from (	Cardiac Catheterizat	April 2010	26		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93528	Deleted from (	Cardiac Catheterizat	April 2010	26		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93529	Deleted from (	Cardiac Catheterizat	April 2010	26		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93539	Deleted from (	Cardiac Catheterizat	February 2008	S		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93540	Deleted from (	Cardiac Catheterizat	February 2008	S		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93541	Deleted from (	Cardiac Catheterizat	April 2010	26		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93542	Deleted from (	Cardiac Catheterizat	April 2010	26		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93543	Deleted from (	Cardiac Catheterizat	February 2009	31		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93544	Deleted from (	Cardiac Catheterizat	February 2008	S		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93545	Deleted from (	Cardiac Catheterizat	February 2009	31		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93555	Deleted from (	Cardiac Catheterizat	February 2009	31		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93556	Deleted from (	Cardiac Catheterizat	February 2009	31		ACC	Deleted fr	Codes Rep	February 2008						FALSE		TRUE	Referred to the CPT Edito	October 2(	13	Deleted	TRUE	Deleted from CPT
93561	Indicator diluti	Cardiac Output Mea	January 2018	27			0.77	Negative I'	October 2(	ZZZ	0	NA	NA	0.00	6	FALSE		FALSE					TRUE	Increase
93562	Indicator diluti	Cardiac Output Mea	January 2018	27			0.95	Negative I'	October 2(	ZZZ	0	NA	NA	0.00	14	FALSE		FALSE					TRUE	Increase
93563	Injection proce	Diagnostic Cardiac C	April 2011	28		ACC	2.00	Codes Reported Toge	ZZZ	1.11	0.39	0.39	0.17	167	FALSE		FALSE		October 2(	13		TRUE	Decrease
93564	Injection proce	Pulmonary Angiogra	October 2021	08	October 2(	RAW	ACC, SCAI	Review ac	Survey Bel	October 2(	ZZZ	1.13	0.39	0.39	0.25	6	FALSE		FALSE					FALSE	
93564	Injection proce	Diagnostic Cardiac C	April 2011	28		ACC	2.10	Codes Reported Toge	ZZZ	1.13	0.39	0.39	0.25	6	FALSE		FALSE		October 2(	13		TRUE	Decrease
93565	Injection proce	Diagnostic Cardiac C	April 2011	28		ACC	1.90	Codes Reported Toge	ZZZ	0.86	0.30	0.30	0.14	80	FALSE		FALSE		October 2(	13		TRUE	Decrease
93566	Injection proce	Diagnostic Cardiac C	April 2011	28		ACC	0.96	Codes Reported Toge	ZZZ	0.86	3.14	0.30	0.16	388	FALSE		FALSE		October 2(	13		TRUE	Decrease
93567	Injection proce	Diagnostic Cardiac C	April 2011	28		ACC	0.97	Codes Reported Toge	ZZZ	0.97	2.33	0.34	0.21	28640	FALSE		FALSE		October 2(	13		TRUE	Decrease
93568	Injection proce	Diagnostic Cardiac C	April 2011	28		ACC	0.98	Codes Reported Toge	ZZZ	0.88	2.81	0.32	0.19	1334	FALSE		TRUE		October 2(	13	Complete	TRUE	Decrease
93571	Intravascular d	Coronary Flow Rese	October 2017	13		ACC, SCAI	1.50	High Volur	October 2(	ZZZ	0	NA	NA	0.00	69945	FALSE		FALSE					TRUE	Decrease
93572	Intravascular d	Coronary Flow Rese	October 2017	13		ACC, SCAI	1.00	High Volur	October 2(	ZZZ	0	NA	NA	0.00	12600	FALSE		FALSE					TRUE	Decrease
93613	Intracardiac el	Cardiac Ablation Ser	April 2021	07		ACC, HRS	5.23	CMS Faste	October 2(	ZZZ	5.23	NA	2.27	1.17	80773	FALSE		FALSE					TRUE	Decrease
93620	Comprehensiv	Intracardiac Cathete	April 2010	45		ACC	11.57	Codes Rep	February 2	000	0	0.00	NA	0.00	8849	FALSE		TRUE	The Workgroup recomme	October 2(	22	Complete	TRUE	Maintain
93621	Comprehensiv	Cardiac Ablation Ser	April 2021	07		ACC, HRS	1.75	High Volur	October 2(	ZZZ	0	0.00	NA	0.00	29892	FALSE		FALSE					TRUE	Decrease
93623	Programmed s	Pacing Heart Stimul	April 2019	22		ACC, HRS	Referral tc	CMS-Othe	October 2(	ZZZ	0	0.00	NA	0.00	38626	FALSE		TRUE	In April 2019, the specialt	May 2019	EC-N	Complete	TRUE	Decrease
93641	Electrophysiol	Insertion/Removal o	September 201	21		ACC	Maintain v	Codes Rep	February 2	000	0	0.00	NA	0.00	14210	FALSE		TRUE	33213 - This code, when (	February 2	13	Complete	TRUE	Maintain
93651	Intracardiac ca	Bundling EPS with Tı	January 2012	11		ACC, HRS	Deleted fr	Codes Rep	February 2010						FALSE		TRUE	The Workgroup recomme	October 2(	22	Complete	TRUE	Deleted from CPT
93652	Intracardiac ca	Bundling EPS with Tı	January 2012	11		ACC, HRS	Deleted fr	CMS Faste	October 2008						FALSE		TRUE	The Workgroup recomme	October 2(	22	Complete	TRUE	Deleted from CPT
93653	Comprehensiv	Cardiac Ablation Ser	April 2021	07		ACC, HRS	15.00	Codes Rep	October 2(	000	14.75	NA	6.40	3.29	31821	FALSE		TRUE	The Workgroup recomme	October 2(	22	Complete	TRUE	Decrease
93654	Comprehensiv	Cardiac Ablation Ser	April 2021	07		ACC, HRS	18.10	Codes Rep	October 2(	000	19.75	NA	8.55	4.41	7750	FALSE		TRUE	The Workgroup recomme	October 2(	22	Complete	TRUE	Decrease
93655	Intracardiac ca	Cardiac Ablation Ser	April 2021	07		ACC, HRS	7.00	Codes Rep	October 2(	ZZZ	7.5	NA	3.27	1.67	31147	FALSE		TRUE	The Workgroup recomme	October 2(	22	Complete	TRUE	Decrease
93656	Comprehensiv	Cardiac Ablation Ser	April 2021	07		ACC, HRS	17.00	Codes Rep	October 2(	000	19.77	NA	8.63	4.42	53327	FALSE		TRUE	In October 2019, the Wor	October 2(	61	complete	TRUE	Decrease
93657	Additional line	Cardiac Ablation Ser	April 2021	07		ACC, HRS	7.00	Codes Rep	October 2(	ZZZ	7.5	NA	3.26	1.67	21959	FALSE		TRUE	The Workgroup recomme	October 2(	22	Complete	TRUE	Decrease
93662	Intracardiac ec	Cardiac Ablation Ser	April 2021	07		ACC, HRS	2.53	High Volur	February 2	ZZZ	0	0.00	NA	0.00	63470	FALSE		FALSE					TRUE	Decrease
93668	Peripheral arte	Peripheral Artery Di	January 2018	28			New PE In	CMS Requ	July 2017	XXX	0	0.40	NA	0.01	814	FALSE		FALSE					TRUE	PE Only
93701	Bioimpedance-derived physiologic		February 2011	41			Remove fr	Low Value	October 2(	XXX	0	0.80	NA	0.01	14268	FALSE		FALSE					TRUE	Remove from Screen
93731	Deleted from (	Cardiology Services	October 2008	26		ACC	Deleted fr	CMS Faste	October 2008							FALSE		FALSE					TRUE	Deleted from CPT
93732	Deleted from (	Cardiology Services	October 2008	26		ACC	Deleted fr	CMS Faste	October 2008							FALSE		FALSE					TRUE	Deleted from CPT
93733	Deleted from (	Cardiology Services	October 2008	26		ACC	Deleted fr	CMS Faste	October 2008							FALSE		FALSE					TRUE	Deleted from CPT
93743	Deleted from (	Cardiology Services	October 2008	26		ACC	Deleted fr	CMS Faste	October 2008							FALSE		FALSE					TRUE	Deleted from CPT
93744	Deleted from (	Cardiology Services	October 2008	26		ACC	Deleted fr	CMS Faste	October 2008							FALSE		FALSE					TRUE	Deleted from CPT
93750	Interrogation (	Ventricular Assist De	April 2019	24		AATS, ACC	0.85	High Volur	October 2(	XXX	0.75	0.59	0.29	0.10	97423	FALSE		FALSE					TRUE	Decrease
93792	Patient/caregi	Home INR Monitorir	January 2020	37	January 2(	RAW		Review in	High Volur	Septembe	XXX	0	1.90	NA	0.04	1742	FALSE		FALSE		Septembe	08	yes	TRUE	PE Only
93793	Anticoagulant	Home INR Monitorir	January 2020	37	January 2(	RAW		Review in	High Volur	Septembe	XXX	0.18	0.14	NA	0.01	1555390	FALSE		FALSE		Septembe	08	yes	TRUE	Maintain
93875	Deleted from (	Noninvasive Vascula	April 2010	45		AAN, ACC,	Deleted fr	Codes Rep	February 2010							TRUE	SS in proce	Yes	TRUE	The Workgroup recomme	October 2(	43	Complete	TRUE	Deleted from CPT
93880	Duplex scan of	Duplex Scans	April 2014	33		ACR, ACC,	0.80	Codes Rep	February 2	XXX	0.8	4.97	NA	0.08	2198611	TRUE	Addressed	Yes	TRUE	The Workgroup recomme	October 2(	43	Complete	TRUE	Increase
93882	Duplex scan of	Duplex Scans	April 2014	33		ACC, ACR,	0.50	CMS High	January 2(	XXX	0.5	3.23	NA	0.08	33564	FALSE			FALSE					TRUE	Increase
93886	Transcranial d	Duplex Scans	April 2014	33		AAN, ACC,	1.00	Codes Rep	February 2	XXX	0.91	7.16	NA	0.07	104495	FALSE			TRUE	The Workgroup recomme	October 2(	CCI edits	Complete	TRUE	Increase
93888	Transcranial d	Duplex Scans	April 2014	33		AAN, ACC,	0.70	Codes Rep	February 2	XXX	0.5	4.34	NA	0.06	10532	FALSE			TRUE	The Workgroup recomme	October 2(	CCI edits	Complete	TRUE	Increase
93890	Transcranial doppler study of the ir		January 2020	37			Remove fr	High Volur	October 2(	XXX	1	7.28	NA	0.08	52137	FALSE			FALSE					TRUE	Remove from Screen
93892	Transcranial doppler study of the ir		January 2020	37			Remove fr	High Volur	October 2(	XXX	1.15	8.14	NA	0.09	55222	FALSE			FALSE					TRUE	Remove from Screen
93895	Quantitative c	Carotid Intima-Medi	April 2015	37		RUC	No Interes	Rescind Ap	New Code	April 2014	XXX	0	0.00	NA	0.00		FALSE		FALSE					TRUE	Not Part of RAW
93922	Limited bilater	Extremity Non-Invas	April 2010	27			SVS, ACR, /	0.25	CMS Faste	October 2(	XXX	0.25	2.20	NA	0.05	694382	FALSE		TRUE	The Workgroup accepted	February 2	58	Revised	TRUE	Maintain
93923	Complete bilat	Extremity Non-Invas	April 2010	27			SVS, ACR, /	0.45	CMS Faste	February 2	XXX	0.45	3.35	NA	0.07	440595	FALSE		TRUE	The Workgroup accepted	February 2	58	Revised	TRUE	Maintain
93924	Noninvasive pl	Extremity Non-Invas	April 2010	27			SVS, ACR, /	0.50	CMS Faste	February 2	XXX	0.5	4.23	NA	0.07	61266	FALSE		TRUE	The Workgroup accepted	February 2	58	Revised	TRUE	Maintain
93925	Duplex scan of	Duplex Scans	April 2014	33		ACC, ACR,	0.80	CMS-Othe	April 2011	XXX	0.8	6.56	NA	0.09	661535	FALSE			FALSE					TRUE	Maintain
93926	Duplex scan of	Duplex Scans	April 2014	33		ACC, ACR,	0.60	CMS-Othe	April 2011	XXX	0.5	3.82	NA	0.07	262918	FALSE			FALSE					TRUE	Increase
93930	Duplex scan of	Duplex Scans	April 2014	33		AAN, ACC,	0.80	CMS Requ	November	XXX	0.8	5.12	NA	0.13	23417	FALSE			FALSE					TRUE	Increase
93931	Duplex scan of	Duplex Scans	April 2014	33		AAN, ACC,	0.50	Codes Rep	February 2	XXX	0.5	3.21	NA	0.07	47500	FALSE			TRUE	The Workgroup recomme	October 2(	CCI edits	Complete	TRUE	Increase
93965	Noninvasive pl	Non-invasive Physio	January 2016	47		ACC, ACR,	Deleted fr	CMS High	July 2015							FALSE		TRUE	In January 2016, the spec	May 2016	28	Complete	TRUE	Deleted from CPT
93970	Duplex scan of	Duplex Scans	April 2014	33		ACC, ACR,	0.70	CMS-Othe	April 2011	XXX	0.7	4.97	NA	0.07	1626806	FALSE			FALSE					TRUE	Maintain
93971	Duplex scan of	Duplex Scans	April 2014	33		ACR, SVS, /	0.45	Low Value	October 2(	XXX	0.45	3.11	NA	0.05	1753619	FALSE			FALSE					TRUE	Maintain
93975	Duplex scan of	Duplex Scans	April 2014	33		ACR, SVS, /	1.30	CMS Requ	November	XXX	1.16	6.85	NA	0.13	218302	FALSE			FALSE					TRUE	Decrease
93976	Duplex scan of	Duplex Scans	April 2014	33		ACR	1.00	CMS Faste	October 2(	XXX	0.8	3.95	NA	0.06	173269	FALSE			FALSE					TRUE	Decrease
93978	Duplex scan of	Duplex Scans	April 2014	33			0.97	CMS-Othe	April 2013	XXX	0.8	4.61	NA	0.12	287616	FALSE			FALSE					TRUE	Increase
93979	Duplex scan of	Duplex Scans	April 2014	33			0.70	CMS-Othe	October 2(	XXX	0.5	3.00	NA	0.07	66512	FALSE			FALSE					TRUE	Increase
93982	Noninvasive pl	Endovascular Repair	January 2017	10		SVS, SIR, S	Deleted fr	Codes Rep	January 2017							FALSE			FALSE					TRUE	Deleted from CPT

93985	Duplex scan of	Duplex Scan Arterial	January 2019	17				0.80	CMS-Othe	October 2(	XXX	0.8	6.89	NA	0.15		FALSE			FALSE		Septembe	36			TRUE	Increase				
93986	Duplex scan of	Duplex Scan Arterial	January 2019	17				0.50	CMS-Othe	October 2(	XXX	0.5	3.95	NA	0.08		FALSE			FALSE		Septembe	36			TRUE	Increase				
93990	Duplex scan of	Doppler Flow Testin	April 2014	40			ACR, SVS	0.60	CMS Faste	October 2(	XXX	0.5	3.90	NA	0.11	132133	FALSE			FALSE						TRUE	Increase				
94010	Spirometry, in	Spirometry	October 2019	12			ATS, CHES	0.17	Low Value	October 2(	XXX	0.17	0.67	NA	0.02	1234541	FALSE			FALSE						TRUE	Maintain				
94014	Patient-initiate	Pulmonary Tests	February 2009	38			ACCP/ATS	Remove fr	High Volur	February 2	XXX	0.52	1.07	NA	0.03	47	FALSE			FALSE						TRUE	Remove from Screen				
94015	Patient-initiate	Pulmonary Tests	February 2009	38			ACCP/ATS	Remove fr	High Volur	February 2	XXX	0	0.89	NA	0.01	38	FALSE			FALSE						TRUE	Remove from Screen				
94016	Patient-initiate	Pulmonary Tests	February 2009	38			ACCP/ATS	Remove fr	High Volur	April 2008	XXX	0.52	0.18	0.18	0.02	5244	FALSE			FALSE						TRUE	Remove from Screen				
94060	Bronchodilatio	Spirometry	October 2019	12			ATS, CHES	0.22	MPC List /	October 2(	XXX	0.22	1.11	NA	0.02	1160195	TRUE	Mar 2014	Yes	FALSE						TRUE	Decrease				
94200	Maximum bre	Lung Function Test	April 2018	28			ATS, CHES	0.05	CMS-Othe	October 2(	XXX	0.05	0.45	NA	0.02	74436	FALSE			FALSE						TRUE	Decrease				
94240	Deleted from (	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The RUC accepted the spe	October 2(	44	Complete		TRUE	Deleted from CPT				
94250	Expired gas co	RAW	October 2019	17				Deleted fr	CMS-Othe	January 2019						20825	FALSE			FALSE						TRUE	Deleted from CPT				
94260	Deleted from (	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The RUC accepted the spe	October 2(	44	Complete		TRUE	Deleted from CPT				
94350	Deleted from (	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The RUC accepted the spe	October 2(	44	Complete		TRUE	Deleted from CPT				
94360	Deleted from (	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The RUC accepted the spe	October 2(	44	Complete		TRUE	Deleted from CPT				
94370	Determination	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The RUC accepted the spe	October 2(	44	Complete		TRUE	Deleted from CPT				
94400	Breathing resp	Evaluation of Whee	April 2019	25			ATS, CHES	Deleted fr	Codes Reported Together 75% or More-Part2 / CPT Assistant Analysis 2018							1310	TRUE	Mar 2014	Yes	TRUE	In January 2019, the RUC	Septembe	49	yes		TRUE	Deleted from CPT				
94450	Breathing resp	Pulmonary Tests	February 2009	38			ACCP/ATS	Remove fr	High Volur	February 2	XXX	0.4	1.35	NA	0.04	56	FALSE			FALSE						TRUE	Remove from Screen				
94617	Exercise test fo	Pulmonary Diagnost	October 2016	05			ATS, CHES	0.70	CMS High	February 2	XXX	0.7	1.98	NA	0.06	9892	FALSE			FALSE		February 2	39	Complete		TRUE	Decrease				
94618	Pulmonary str	Pulmonary Diagnost	October 2016	05			ATS, CHES	0.48	CMS High	February 2	XXX	0.48	0.46	NA	0.03	271019	FALSE			FALSE		February 2	39	Complete		TRUE	Decrease				
94620	Pulmonary str	Pulmonary Diagnost	October 2016	05			ATS, CHES	Deleted fr	CMS High	July 2015							FALSE			TRUE	In January 2016, the spec	February 2	39	Complete		TRUE	Deleted from CPT				
94621	Cardiopulmon	Pulmonary Diagnost	October 2016	05			ATS, CHES	1.42	CMS High	January 2(	XXX	1.42	3.07	NA	0.10	21378	FALSE			TRUE	In January 2016, the spec	February 2	39	Complete		TRUE	Maintain				
94640	Pressurized or	Evaluation of Whee	April 2019	25			AAFP, ATS	New PE In	Codes Reported Toge		XXX	0	0.40	NA	0.01	601038	TRUE	Mar 2014	Yes	FALSE						TRUE	PE Only				
94667	Manipulation (	Evaluation of Whee	April 2019	25			ATS, CHES	New PE In	CPT Assist	April 2019	XXX	0	0.61	NA	0.01	6331	FALSE			FALSE						TRUE	PE Only				
94668	Manipulation (	Evaluation of Whee	April 2019	25			AAFP, ATS	New PE In	Codes Reported Toge		XXX	0	0.94	NA	0.02	5171	TRUE	Mar 2014	Yes	FALSE						TRUE	PE Only				
94669	Mechanical ch	Evaluation of Whee	April 2019	25			ATS, CHES	New PE In	CPT Assist	April 2019	XXX	0	0.65	NA	0.02	324	FALSE			FALSE						TRUE	PE Only				
94681	Oxygen uptake	Pulmonary Tests	September 201	51			AACE, TES	Remove fr	High Volur	February 2	XXX	0.2	1.27	NA	0.02	7816	FALSE			FALSE						TRUE	Remove from Screen				
94720	Carbon monox	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The RUC accepted the spe	October 2(	44	Complete		TRUE	Deleted from CPT				
94725	Membrane dif	Pulmonary Tests	April 2010	45			ACCP, ATS	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The RUC accepted the spe	October 2(	44	Complete		TRUE	Deleted from CPT				
94726	Plethysmograp	Pulmonary Function	April 2011	19			ACCP, ATS	0.31	Codes Rep	February 2	XXX	0.26	1.30	NA	0.03	681512	FALSE			FALSE		February 2011				TRUE	Decrease				
94727	Gas dilution or	Pulmonary Function	April 2011	19			ACCP, ATS	0.31	Codes Rep	February 2	XXX	0.26	1.00	NA	0.02	348523	FALSE			FALSE		February 2011				TRUE	Decrease				
94728	Airway resista	Pulmonary Function	April 2011	19			ACCP, ATS	0.31	Codes Rep	February 2	XXX	0.26	0.91	NA	0.02	4985	FALSE			FALSE		February 2011				TRUE	Decrease				
94729	Diffusing capa	Pulmonary Function	April 2011	19			ACCP, ATS	0.19	Codes Rep	February 2	ZZZ	0.19	1.52	NA	0.02	1113315	FALSE			FALSE		February 2011				TRUE	Decrease				
94750	Pulmonary cor	RAW	October 2019	17				Deleted fr	CMS-Othe	January 2019						18981	FALSE			FALSE						TRUE	Deleted from CPT				
94760	Noninvasive e	Measure Blood Oxyg	February 2009	32			ACCP, ATS	New PE in	CMS Requ	NA	XXX	0	0.06	NA	0.01	29834	FALSE			FALSE						TRUE	PE Only				
94761	Noninvasive e	Measure Blood Oxyg	February 2009	32			ACCP, ATS	New PE in	CMS Requ	NA	XXX	0	0.10	NA	0.01	16501	FALSE			FALSE						TRUE	PE Only				
94762	Noninvasive e	Measure Blood Oxyg	February 2009	32			ACCP, ATS	New PE in	CMS Faste	October 2(	XXX	0	0.78	NA	0.01	208171	FALSE			FALSE						TRUE	PE Only				
94770	Carbon dioxide	Evaluation of Whee	April 2019	25			ATS, CHES	Deleted fr	High Volur	February 2008						5724	TRUE	Mar 2014	Yes	TRUE	In April 2019, when revie	Septembe	49	yes		TRUE	Deleted from CPT				
95004	Percutaneous	Percutaneous Allerg	October 2016	27	RUC		AAAAI, AA	0.01	Low Value	October 2(	XXX	0.01	0.10	NA	0.01	10738966	FALSE			FALSE						TRUE	Maintain				
95010	Percutaneous	Percutaneous Allerg	April 2011	31			JCAAI, ACA	Deleted fr	Low Value	October 2010							FALSE			TRUE	The specialty societies inc	February 2	15	Complete		TRUE	Deleted from CPT				
95012	Nitric oxide ex	Exhaled Nitric Oxide	April 2019	26			AAAAI, AC	New PE In	High Volur	October 2(	XXX	0	0.57	NA	0.01	136728	FALSE			FALSE						TRUE	PE Only				
95015	Intracutaneou	Intracutaneous Allge	April 2011	31			JCAAI, ACA	Deleted fr	Low Value	October 2010							FALSE			TRUE	The specialty societies inc	February 2	15	Complete		TRUE	Deleted from CPT				
95017	Allergy testing	Percutaneous Allerg	April 2012	29			JCAAI	0.07	Low Value	October 2(	XXX	0.07	0.17	0.03	0.01	27662	FALSE			TRUE	Deleted codes 95010 and	February 2	15	Complete		TRUE	Decrease				
95018	Allergy testing	Percutaneous Allerg	April 2012	29			JCAAI	0.14	Low Value	October 2(	XXX	0.14	0.47	0.06	0.01	129391	FALSE			TRUE	Deleted codes 95010 and	February 2	15	Complete		TRUE	Decrease				
95024	Intracutaneou	Intracutaneous Allge	October 2017	19			JCAAI, ACA	New PE In	Low Value	October 2(	XXX	0.01	0.23	0.01	0.01	1833929	FALSE			FALSE						TRUE	PE Only				
95027	Intracutaneou	Intracutaneous Allge	February 2011	41			JCAAI, ACA	0.01	Low Value	October 2(	XXX	0.01	0.12	NA	0.01	164524	FALSE			FALSE						TRUE	Maintain				
95115	Professional se	Immunotherapy Inje	April 2012	48			JCAAI, AAC	New PE In	CMS High	January 2(	XXX	0	0.26	NA	0.01	1034318	FALSE			FALSE						TRUE	PE Only				
95117	Professional se	Immunotherapy Inje	April 2012	48			JCAAI, AAC	New PE In	CMS High	Septembe	XXX	0	0.32	NA	0.01	2769382	FALSE			FALSE						TRUE	PE Only				
95144	Professional se	Antigen Therapy Ser	January 2016	49			AAOHNS, A	0.06	Low Value	October 2(	XXX	0.06	0.41	0.02	0.01	178622	FALSE			FALSE						TRUE	Maintain				
95148	Professional services for the supen		October 2010	73				0.06	Low Value	October 2(	XXX	0.06	2.59	0.02	0.01	20261	FALSE			FALSE						TRUE	Maintain				
95165	Professional se	Antigen Therapy Ser	January 2016	49			AAOHNS, A	0.06	MPC List /	October 2(	XXX	0.06	0.39	0.02	0.01	7687749	FALSE			FALSE						TRUE	Maintain				
95249	Ambulatory co	Continuous Glucose	April 2017	08			AACE, ES,	PE Only. R	High Volume Growth		XXX	0	1.64	NA	0.04	10730	TRUE	June 2018	yes	TRUE	The RUC recommends ref	June 2017	EC	yes		TRUE	PE Only				
95250	Ambulatory co	Continuous Glucose	January 2020	37	January 2(	RAW	AACE, ES	Re-review	High Volur	October 2(	XXX	0	4.47	NA	0.04	76885	FALSE			TRUE	In May 2014, the CPT Edit	October 2(	38	yes		TRUE	PE Only				
95251	Ambulatory co	Continuous Glucose	January 2020	37	January 2(	RAW	AACE, ES	Re-review	High Volur	April 2013	XXX	0.7	0.28	0.28	0.04	248288	FALSE			TRUE	In October 2016, at the PI	February 2	38	yes		TRUE	Decrease				
95700	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95705	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95706	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95707	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95708	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95709	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95710	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95711	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95712	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95713	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95714	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95715	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95716	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	PE Only	High Volur	May 2018	XXX	0	0.00	0.00	0.00		FALSE			FALSE						TRUE	PE Only				
95717	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	2.00	High Volur	May 2018	XXX	2	0.82	0.79	0.14		FALSE			FALSE						TRUE	Decrease				
95718	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	2.50	High Volur	May 2018	XXX	2.5	1.25	1.18	0.20		FALSE			FALSE						TRUE	Decrease				
95719	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	3.00	High Volur	May 2018	XXX	3	1.37	1.32	0.21		FALSE			FALSE						TRUE	Decrease				
95720	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	3.86	High Volur	May 2018	XXX	3.86	1.91	1.82	0.28		FALSE			FALSE						TRUE	Decrease				
95721	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	3.86	High Volur	May 2018	XXX	3.86	1.95	1.83	0.28		FALSE			FALSE						TRUE	Decrease				
95722	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	4.70	High Volur	May 2018	XXX	4.7	2.36	2.22	0.36		FALSE			FALSE						TRUE	Decrease				
95723	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	4.75	High Volur	May 2018	XXX	4.75	2.45	2.28	0.37		FALSE			FALSE						TRUE	Decrease				
95724	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	6.00	High Volur	May 2018	XXX	6	3.02	2.84	0.45		FALSE			FALSE						TRUE	Decrease				
95725	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	5.40	High Volur	May 2018	XXX	5.4	2.82	2.61	0.43		FALSE			FALSE						TRUE	Decrease				
95726	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	7.58	High Volur	May 2018	XXX	7.58	3.83	3.59	0.59		FALSE			FALSE						TRUE	Decrease				
95800	Sleep study, ur	Sleep Testing	April 2010	28			ACNS, AAN	1.05	CMS Faste	October 2(	XXX	0.85	3.98	NA	0.05	24715	FALSE			FALSE		October 2009				TRUE	Decrease				
95801	Sleep study, ur	Sleep Testing	April 2010	28			ACNS, AAN	1.00	CMS Faste	October 2(	XXX	0.85	1.72	NA	0.05	422	FALSE			FALSE		October 2009				TRUE	Decrease				
95803	Actigraphy tes	Sleep Testing	April 2010	28			ACNS, AAN	0.90 and N	CMS Requ	NA	XXX	0.9	3.55	NA	0.05	232	FALSE			FALSE						TRUE	Decrease				
95805	Multiple sleep	Sleep Testing	April 2010	28			ACNS, AAN	1.20	CMS Faste	October 2(	XXX	1.2	10.97	NA	0.13	3017	FALSE			FALSE		October 2009				TRUE	Decrease				

95806	Sleep study, ur	Sleep Testing	April 2010	28			ACNS, AAN	1.28	CMS Faste	October 2(	XXX	0.93	1.95	NA	0.06	80376	FALSE			FALSE		October 2009			TRUE	Decrease
95807	Sleep study, si	Sleep Testing	April 2010	28			ACNS, AAN	1.25	CMS Faste	October 2(	XXX	1.28	10.24	NA	0.14	3278	FALSE			FALSE		October 2009			TRUE	Decrease
95808	Polysomnogra	Sleep Testing	April 2010	28			ACNS, AAN	1.74	CMS Faste	October 2(	XXX	1.74	17.45	NA	0.15	1197	FALSE			FALSE		October 2009			TRUE	Decrease
95810	Polysomnogra	Sleep Testing	April 2010	28			ACNS, AAN	2.50	CMS Faste	February 2	XXX	2.5	15.30	NA	0.22	272131	FALSE			FALSE		October 2009			TRUE	Decrease
95811	Polysomnogra	Sleep Testing	April 2010	28			ACNS, AAN	2.60	CMS Faste	October 2(	XXX	2.6	15.99	NA	0.22	333381	FALSE			FALSE		October 2009			TRUE	Decrease
95812	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	1.08	CMS Requ	July 2015	XXX	1.08	8.96	NA	0.09	24822	FALSE			FALSE					TRUE	Maintain
95813	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	1.63	CMS Requ	July 2015	XXX	1.63	10.70	NA	0.13	31299	FALSE			FALSE					TRUE	Decrease
95816	Electroenceph	Electroencephalogra	October 2012	22				1.08	CMS High	January 2(	XXX	1.08	9.91	NA	0.09	278212	FALSE			FALSE					TRUE	Maintain
95819	Electroenceph	Electroencephalogra	October 2012	22			AAN, ACN	1.08	CMS High	Septembe	XXX	1.08	12.12	NA	0.09	202028	FALSE			FALSE					TRUE	Maintain
95822	Electroenceph	Electroencephalogra	October 2012	22			AAN, ACN	1.08	CMS High	January 2(	XXX	1.08	10.95	NA	0.09	26955	FALSE			FALSE					TRUE	Maintain
95827	Electroenceph	Long-Term EEG Mor	October 2018	13			AAN, ACN	Deleted fr	High Volur	May 2018						5020	FALSE			FALSE					TRUE	Deleted from CPT
95831	Muscle testing	Muscle Testing	April 2018	33			AAN, AAN	Deleted fr	High Volur	October 2015						79780	FALSE			TRUE	In April 2018, AAN, AANE	Septembe	39	complete	TRUE	Deleted from CPT
95832	Muscle testing	Muscle Testing	April 2018	33			AAN, AAN	Deleted fr	High Volur	October 2017						11062	FALSE			TRUE	In April 2018, AAN, AANE	Septembe	39	complete	TRUE	Deleted from CPT
95833	Muscle testing	Muscle Testing	April 2018	33			AAN, AAN	Deleted fr	High Volur	October 2017						867	FALSE			TRUE	In April 2018, AAN, AANE	Septembe	39	complete	TRUE	Deleted from CPT
95834	Muscle testing	Muscle Testing	April 2018	33			AAN, AAN	Deleted fr	High Volur	October 2017						605	FALSE			TRUE	In April 2018, AAN, AANE	Septembe	39	complete	TRUE	Deleted from CPT
95860	Needle electro	EMG in Conjunction	April 2012	32			AAN, AAPI	0.96	Harvard V	October 2(	XXX	0.96	2.48	NA	0.05	2418	FALSE			TRUE	The Workgroup, accepts	February 2	09	Complete	TRUE	Maintain
95861	Needle electro	EMG in Conjunction	April 2012	32			AAN, AAPI	1.54	Codes Rep	February 2	XXX	1.54	3.43	NA	0.07	44204	FALSE			TRUE	The Workgroup, accepts	February 2	09	Complete	TRUE	Maintain
95863	Needle electro	EMG in Conjunction	April 2012	32			AAN, AAPI	1.87	Codes Rep	February 2	XXX	1.87	4.63	NA	0.07	157	FALSE			TRUE	The Workgroup, accepts	February 2	09	Complete	TRUE	Maintain
95864	Needle electro	EMG in Conjunction	April 2012	32			AAN, AAPI	1.99	Codes Rep	February 2	XXX	1.99	5.25	NA	0.11	1620	FALSE			TRUE	The Workgroup, accepts	February 2	09	Complete	TRUE	Maintain
95867	Needle electro	EMG in Conjunction	April 2012	32			AAN, AAPI	0.79	Codes Rep	October 2(	XXX	0.79	2.45	NA	0.05	1113	FALSE			TRUE	Identifed by CPT with nee	October 2(	06	Complete	TRUE	Maintain
95868	Needle electro	EMG in Conjunction	April 2012	32			AAN, AAPI	1.18	Codes Rep	October 2(	XXX	1.18	3.05	NA	0.06	5630	FALSE			TRUE	Identifed by CPT with nee	October 2(	06	Complete	TRUE	Maintain
95869	Needle electro	EMG in Conjunction	April 2012	32			AAN, AAPI	0.37	Codes Rep	October 2(	XXX	0.37	2.60	NA	0.03	447	FALSE			TRUE	Identifed by CPT with nee	October 2(	06	Complete	TRUE	Maintain
95870	Needle electro	EMG in Conjunction	October 2017	19			AAN, AAPI	0.37	Codes Rep	October 2(	XXX	0.37	2.28	NA	0.03	52835	FALSE			TRUE	Identifed by CPT with nee	October 2(	06	Complete	TRUE	Maintain
95885	Needle electro	EMG in Conjunction	April 2011	20			AAN, AAPI	0.35	Codes Rep	February 2	ZZZ	0.35	1.59	NA	0.01	141249	FALSE			FALSE	CPT Feb 2011, addition of	February 2	09	Complete	TRUE	Decrease
95886	Needle electro	EMG in Conjunction	April 2011	20			AAN, AAPI	0.92	Codes Rep	February 2	ZZZ	0.86	2.09	NA	0.04	962501	FALSE			FALSE	CPT Feb 2011, addition of	February 2	09	Complete	TRUE	Decrease
95887	Needle electro	EMG in Conjunction	April 2011	20			AAN, AAPI	0.73	Codes Rep	February 2	ZZZ	0.71	1.84	NA	0.04	14870	FALSE			FALSE	CPT Feb 2011, addition of	February 2	09	Complete	TRUE	Decrease
95900	Nerve conduct	EMG in Conjunction	April 2012	32			AAN, AAPI	Deleted fr	MPC List /	October 2010							FALSE			TRUE	Identified as part of the R	October 2(	06 & 16	Complete	TRUE	Deleted from CPT
95903	Nerve conduct	EMG in Conjunction	April 2012	32			AAN, AAPI	Deleted fr	CMS High	September 2011							FALSE			TRUE	Identified as part of the R	October 2(	06 & 16	Complete	TRUE	Deleted from CPT
95904	Nerve conduct	EMG in Conjunction	April 2012	32			AAN, AAPI	Deleted fr	Codes Rep	February 2010							FALSE			TRUE	The Workgroup, accepts	February 2	09 & 16	Complete	TRUE	Deleted from CPT
95907	Nerve conduct	EMG in Conjunction	April 2012	32			AAN, AAPI	1.00	Codes Rep	October 2(	XXX	1	1.73	NA	0.05	6263	FALSE			TRUE	Deleted 6 electromyogra	February 2	16	Complete	TRUE	Decrease
95908	Nerve conduct	EMG in Conjunction	April 2012	32			AAN, AAPI	1.37	Codes Rep	October 2(	XXX	1.25	2.20	NA	0.06	58348	FALSE			TRUE	Deleted 6 electromyogra	February 2	16	Complete	TRUE	Decrease
95909	Nerve conduct	EMG in Conjunction	April 2012	32			AAN, AAPI	1.77	Codes Rep	October 2(	XXX	1.5	2.63	NA	0.06	134007	FALSE			TRUE	Deleted 6 electromyogra	February 2	16	Complete	TRUE	Decrease
95910	Nerve conduct	EMG in Conjunction	April 2012	32			AAN, AAPI	2.80	Codes Rep	October 2(	XXX	2	3.41	NA	0.10	157766	FALSE			TRUE	Deleted 6 electromyogra	February 2	16	Complete	TRUE	Decrease
95911	Nerve conduct	EMG in Conjunction	April 2012	32			AAN, AAPI	3.34	Codes Rep	October 2(	XXX	2.5	4.00	NA	0.11	175960	FALSE			TRUE	Deleted 6 electromyogra	February 2	16	Complete	TRUE	Decrease
95912	Nerve conduct	EMG in Conjunction	April 2012	32			AAN, AAPI	4.00	Codes Rep	October 2(	XXX	3	4.50	NA	0.15	78978	FALSE			TRUE	Deleted 6 electromyogra	February 2	16	Complete	TRUE	Decrease
95913	Nerve conduct	EMG in Conjunction	April 2012	32			AAN, AAPI	4.20	Codes Rep	October 2(	XXX	3.56	5.15	NA	0.17	81707	FALSE			TRUE	Deleted 6 electromyogra	February 2	16	Complete	TRUE	Decrease
95921	Testing of autc	Autonomic Function	January 2020	37	October 2(	RAW	AAFP, AAN	Refer to Cl	Different F	October 2(	XXX	0.9	1.66	NA	0.05	54178	TRUE	Sep 2020	complete	TRUE	For code pair 95921/9592	February 2	17	Complete	TRUE	Maintain
95922	Testing of autc	Autonomic Function	January 2020	37	October 2(	RAW	AAFP, AAN	Refer to Cl	High Volur	February 2	XXX	0.96	2.08	NA	0.06	2986	TRUE	Dec 2008;	complete	TRUE	For code pair 95921/9592	February 2	17	Complete	TRUE	Maintain
95923	Testing of autc	Autonomic Function	January 2020	37	October 2(	RAW	AAFP, AAN	Refer to Cl	Codes Rep	October 2(	XXX	0.9	2.88	NA	0.05	114086	TRUE	Sep 2020	complete	FALSE					FALSE	Maintain
95924	Testing of autc	Autonomic Function	January 2020	37	October 2(	RAW	AAFP, AAN	Refer to Cl	Codes Rep	Codes Reported Toge	XXX	1.73	2.58	NA	0.11	21055	TRUE	Sep 2020	complete	TRUE	CPT Feb 2012 established	February 2	17	Complete	TRUE	Decrease
95925	Short-latency s	Evoked Potentials ar	January 2013	34			AAN, AAN	0.54 and N	Codes Rep	February 2	XXX	0.54	4.02	NA	0.06	5861	FALSE			TRUE	The Workgroup recomme	October 2(	48	Complete	TRUE	Maintain
95926	Short-latency s	Evoked Potentials ar	January 2013	34			AAN, AAN	0.54 and N	Codes Rep	February 2	XXX	0.54	3.68	NA	0.04	6658	FALSE			TRUE	The Workgroup recomme	October 2(	48	Complete	TRUE	Maintain
95928	Central motor	Evoked Potentials ar	April 2013	36			AAN, AAN	1.50	Codes Rep	February 2	XXX	1.5	5.39	NA	0.07	325	FALSE			TRUE	The Workgroup recomme	October 2(	48	Complete	TRUE	Maintain
95929	Central motor	Evoked Potentials ar	April 2013	36			AAN, AAN	1.50	Codes Rep	February 2	XXX	1.5	5.60	NA	0.06	1333	FALSE			TRUE	The Workgroup recomme	October 2(	48	Complete	TRUE	Maintain
95930	Visual evoked	Visual Evoked Poten	October 2016	11			AAO, AOA	0.35	High Volur	October 2(	XXX	0.35	1.60	NA	0.02	53881	FALSE			TRUE	In January 2016, the RUC	May 2016	29	Complete	TRUE	Maintain
95934	H-reflex, ampli	EMG in Conjunction	April 2012	32				Deleted fr	Codes Reported Together 75% or More-Part1								FALSE			TRUE	Identified as part of the C	October 2(	06 & 16	Complete	TRUE	Deleted from CPT
95936	H-reflex, ampli	EMG in Conjunction	April 2012	32				Deleted fr	Codes Reported Together 75% or More-Part1								FALSE			TRUE	Identified as part of the C	October 2(	06 & 16	Complete	TRUE	Deleted from CPT
95938	Short-latency s	Evoked Potentials ar	January 2013	34			AAN, AAN	0.86 and n	Codes Rep	January 2(	XXX	0.86	9.64	NA	0.08	90204	FALSE			TRUE		October 2(	48	Complete	TRUE	Decrease
95939	Central motor	Evoked Potentials ar	January 2013	34			AAN, AAN	2.25 and n	Codes Rep	January 2(	XXX	2.25	13.62	NA	0.15	41818	FALSE			TRUE		October 2(	48	Complete	TRUE	Decrease
95940	Continuous int	Intraoperative Neur	January 2012	12				0.60	Codes Rep	January 2(	XXX	0.6	NA	0.31	0.04	25807	FALSE			TRUE	Deleted 6 electromyogra	February 2	16	Complete	TRUE	Decrease
95941	Continuous int	Intraoperative Neur	January 2012	12				2.00	Codes Rep	January 2(	XXX	0	0.00	0.00	0.00		FALSE			TRUE	Deleted 6 electromyogra	February 2	16	Complete	TRUE	Decrease
95943	Simultaneous,	Autonomic Function	January 2020	37			AAN, AAN	Deleted fr	Codes Rep	January 2(	XXX	0	0.00	NA	0.00	22723	FALSE			TRUE	In January 2018, a RUC m	October 2(	65	complete	TRUE	Deleted from CPT
95950	Monitoring for	Long-Term EEG Mor	October 2018	13			AAN, ACN	Deleted fr	CMS Faste	February 2009						2415	FALSE			FALSE					TRUE	Deleted from CPT
95951	Monitoring for	Long-Term EEG Mor	October 2018	13				Deleted fr	High Volur	October 2016						188070	FALSE			TRUE	This service was identifec	May 2018	35	Yes	TRUE	Deleted from CPT
95953	Monitoring for	Long-Term EEG Mor	October 2018	13			AAN, ACN	Deleted fr	CMS Faste	February 2009						24927	FALSE			FALSE					TRUE	Deleted from CPT
95954	Pharmacologic	EEG Monitoring	February 2008	S			AAN, ACN	Remove fr	High Volur	February 2	XXX	2.45	8.95	NA	0.16	623	FALSE			FALSE					TRUE	Remove from Screen
95956	Monitoring for	Long-Term EEG Mor	October 2018	13			AAN, ACN	Deleted fr	CMS Faste	October 2008						5307	TRUE	Dec 2009	Yes	FALSE					TRUE	Deleted from CPT
95957	Digital analysis	Electroencephalogra	January 2016	50			AAN	1.98	CMS High	July 2015	XXX	1.98	5.29	NA	0.13	61055	FALSE			FALSE					TRUE	Maintain
95970	Electronic anal	Neurostimulator Ser	January 2019	37			AAN, AAN	0.45	Harvard V	February 2	XXX	0.35	0.17	0.16	0.04	38689	TRUE	Jul 2016	Yes	TRUE	In January 2016, the spec	June 2017	31	Complete	TRUE	Maintain
95971	Electronic anal	Neurostimulator Ser	October 2017	07			AUA, ACO	0.78	Harvard V	October 2(	XXX	0.78	0.59	0.32	0.06	21590	FALSE			TRUE	In January 2014, the RUC	February 2	75, 31	Complete	TRUE	Maintain
95972	Electronic anal	Neurostimulator Ser	October 2017	07			AUA, ACO	0.80	Harvard V	February 2	XXX	0.8	0.76	0.31	0.09	46946	FALSE			TRUE	In January 2014, the RUC	May 2014	EC1	Complete	TRUE	Decrease
95973	Electronic anal	Implanted Neurostir	April 2015	21			AANS/CNS	Deleted fr	Harvard V	February 2010							FALSE			TRUE	In January 2014, the RUC	February 2	75	Complete	TRUE	Deleted from CPT
95974	Electronic anal	Neurostimulator Ser	October 2017	07			AAN, AAN	Deleted fr	CMS Requ	July 2015							TRUE	Jul 2016	Yes	TRUE	In January 2016, the spec	June 2017	31	Complete	TRUE	Deleted from CPT
95975	Electronic anal	Neurostimulator Ser	October 2017	07			AAN, AAN	Deleted fr	CMS Requ	July 2015							TRUE	Jul 2016	Yes	TRUE	In January 2016, the spec	June 2017	31	Complete	TRUE	Deleted from CPT
95976	Electronic anal	Neurostimulator Ser	October 2017	07			AAN, AAN	0.95 and R	High Volur	June 2017	XXX	0.73	0.38	0.36	0.06	8660	TRUE	February 2	complete	FALSE		June 2017	31		TRUE	Maintain
95977	Electronic anal	Neurostimulator Ser	October 2017	07			AAN, AAN	1.19 and R	High Volur	June 2017	XXX	0.97	0.50	0.47	0.10	7130	TRUE	February 2	complete	FALSE		June 2017	31		TRUE	Maintain
95978	Electronic anal	Neurostimulator Ser	October 2017	07			AAN, AAN	Deleted fr	CMS Requ	July 2015							TRUE	Jul 2016	Yes	TRUE	In January 2016, the spec	June 2017	31	Complete	TRUE	Deleted from CPT
95979	Electronic anal	Neurostimulator Ser	October 2017	07			AAN, AAN	Deleted fr	CMS Requ	July 2015							TRUE	Jul 2016	Yes	TRUE	In January 2016, the spec	June 2017	31	Complete	TRUE	Deleted from CPT
95980	Electronic anal	Neurostimulator Ser	October 2017	07			No Interes	Not part o	CMS Requ	July 2015	XXX	0.8	NA	0.35	0.17	570	FALSE			FALSE	CPT codes 95971-95973 v	June 2017	31	Complete	TRUE	Maintain
95981	Electronic anal	Neurostimulator Ser	October 2017	07			No Interes	Not part o	CMS Requ	July 2015	XXX	0.3	0.73	0.17	0.05	843	FALSE			FALSE	CPT codes 95971-95973 v	June 2017	31	Complete	TRUE	Maintain
95982	Electronic anal	Neurostimulator Ser	January 2016	07			No Interes	Not part o	CMS Requ	July 2015	XXX	0.65	0.93	0.31	0.13	1278	FALSE			FALSE	CPT codes 95971-95973 v	June 2017	31	Complete	TRUE	Maintain
95983	Electronic anal	Neurostimulator Ser	October 2017	07			AAN, AAN	1.25 and R	High Volur	June 2017	XXX	0.91	0.48	0.45	0.10	40522	TRUE	February 2	complete	FALSE		June 2017	31		TRUE	Maintain
95984	Electronic anal	Neurostimulator Ser	October 2017	07			AAN, AAN	1.00 and R	High Volur	June 2017	ZZZ	0.8	0.41	0.40	0.09	58079	TRUE	February 2	complete	FALSE		June 2017	31		TRUE	Maintain
95990	Refilling and m	Electronic Analysis Ir	February 2011	07			ASA, AAPN	0.00	Different F	April 2010	XXX	0	2.68	NA	0.04	1124	FALSE			TRUE	Identified through the Co	October 2010		Complete	TRUE	Maintain
95991	Refilling and m	Electronic Analysis Ir	February 2011	07			ASA, AAPN	0.77	High Volur	February 2	XXX	0.77	2.50	0.32	0.09	8596	FALSE			TRUE		October 2010		Complete	TRUE	Maintain
95992	Canalith repositioning procedure(s)		April 2018	33				Remove fr	Modifier -!	January 2(	XXX	0.75	0.49	0.28	0.04	112529	FALSE			FALSE					TRUE	Maintain
96101	Psychological t	Psychological and Ne	October 2017	08			APA (psycl	Deleted fr	CMS High	July 2015							FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Deleted from CPT
96102	Psychological t	Psychological and Ne	October 2017	08			APA (psycl	Deleted fr	CMS High	July 2015							FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Deleted from CPT
96103	Psychological t	Psychological and Ne	October 2017	08			APA (psycl	Deleted fr	High Volur	April 2013							FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Deleted from CPT
96105	Assessment of	Psychological and Ne	October 2017	20			APA (psycl	1.75	CMS Requ	January 2(	XXX	1.75	1.06	NA	0.10	1273	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Decrease

96110	Developmenta	Psychological and N	October 2017	08			APA (psycl	New PE In	CMS High	January 20	XXX	0	0.28	NA	0.01		FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	PE Only
96111	Developmenta	Psychological and N	October 2017	08			APA (psycl	Deleted fr	CMS High	January 2017							FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Deleted from CPT
96112	Developmenta	Psychological and N	October 2017	08			APA (psycl	2.50	CMS High	June 2017	XXX	2.56	1.07	1.01	0.14	1417	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Decrease
96113	Developmenta	Psychological and N	October 2017	08			APA (psycl	1.10	CMS High	June 2017	ZZZ	1.16	0.47	0.35	0.05	132	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Decrease
96116	Neurobehavio	Psychological and N	October 2017	08			APA (psycl	1.86	CMS High	July 2015	XXX	1.86	0.83	0.45	0.09	157733	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Maintain
96118	Neuropsychol	Psychological and N	October 2017	08			APA (psycl	Deleted fr	CMS High	July 2015							FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Deleted from CPT
96119	Neuropsychol	Psychological and N	October 2017	08			APA (psycl	Deleted fr	CMS High	July 2015							FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Deleted from CPT
96120	Neuropsychol	Psychological and N	October 2017	08			APA (psycl	Deleted fr	High Volur	April 2013							FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Deleted from CPT
96121	Neurobehavio	Psychological and N	October 2017	08			APA (psycl	1.71	CMS High	June 2017	ZZZ	1.71	0.56	0.33	0.09	47794	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Decrease
96125	Standardized c	Psychological and N	October 2017	20			APA (psycl	1.70	CMS High	January 20	XXX	1.7	1.28	NA	0.09	4262	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Maintain
96127	Brief emotiona	Psychological and N	October 2017	08			APA (psycl	New PE In	CMS High	January 20	XXX	0	0.13	NA	0.01	492372	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	PE Only
96130	Psychological t	Psychological and N	October 2017	20			APA (psycl	2.50	CMS High	June 2017	XXX	2.56	0.79	0.44	0.11	99759	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Decrease
96131	Psychological t	Psychological and N	October 2017	20			APA (psycl	1.90	CMS High	June 2017	ZZZ	1.96	0.57	0.29	0.09	80133	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Decrease
96132	Neuropsychol	Psychological and N	October 2017	08			APA (psycl	2.50	CMS High	June 2017	XXX	2.56	1.16	0.38	0.10	194323	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Decrease
96133	Neuropsychol	Psychological and N	October 2017	08			APA (psycl	1.90	CMS High	June 2017	ZZZ	1.96	0.96	0.27	0.06	339426	FALSE			TRUE	In the July 2015 Proposec	June 2017	32	complete	TRUE	Decrease
96136	Psychological (	Psychological and N	October 2017	20			APA (psycl	0.55	CMS High	June 2017	XXX	0.55	0.75	0.11	0.04	173801	FALSE			FALSE		June 2017	32		TRUE	Decrease
96137	Psychological (	Psychological and N	October 2017	20			APA (psycl	0.46	CMS High	June 2017	ZZZ	0.46	0.72	0.06	0.02	379620	FALSE			FALSE		June 2017	32		TRUE	Decrease
96138	Psychological (	Psychological and N	October 2017	20			APA (psycl	New PE In	CMS High	June 2017	XXX	0	1.06	NA	0.01	157925	FALSE			FALSE		June 2017	32		TRUE	PE Only
96139	Psychological (	Psychological and N	October 2017	20			APA (psycl	New PE In	CMS High	June 2017	ZZZ	0	1.06	NA	0.01	353021	FALSE			FALSE		June 2017	32		TRUE	PE Only
96146	Psychological (	Psychological and N	October 2017	20			APA (psycl	New PE In	CMS High	June 2017	XXX	0	0.05	NA	0.01	27702	FALSE			FALSE		June 2017	32		TRUE	PE Only
96150	Health and bel	Health and Behavior	January 2019	41				Deleted fr	Negative I	September 2018						54601	FALSE			FALSE		Septembe	40	Complete	TRUE	Deleted from CPT
96151	Health and bel	Health and Behavior	January 2019	41				Deleted fr	Negative I	September 2018						10113	FALSE			FALSE		Septembe	40	Complete	TRUE	Deleted from CPT
96152	Health and bel	Health and Behavior	January 2019	41				Deleted fr	Negative I	September 2018						103595	FALSE			FALSE		Septembe	40	Complete	TRUE	Deleted from CPT
96153	Health and bel	Health and Behavior	January 2019	41				Deleted fr	Negative I	September 2018						42795	FALSE			FALSE		Septembe	40	Complete	TRUE	Deleted from CPT
96154	Health and bel	Health and Behavior	January 2019	41			APA (psycl	Deleted fr	Negative I	April 2017						8583	FALSE			TRUE	In October 2017, the spec	Septembe	40	Complete	TRUE	Deleted from CPT
96155	Health and bel	Health and Behavior	January 2019	41				Deleted fr	Negative I	September 2018							FALSE			FALSE		Septembe	40	Complete	TRUE	Deleted from CPT
96156	Health behavic	Health and Behavior	January 2019	41				2.10	Negative I	Septembe	XXX	2.1	0.60	0.28	0.09		FALSE			FALSE		Septembe	40	Complete	TRUE	Increase
96158	Health behavic	Health and Behavior	January 2019	41				1.45	Negative I	Septembe	XXX	1.45	0.41	0.19	0.05		FALSE			FALSE		Septembe	40	Complete	TRUE	Increase
96159	Health behavic	Health and Behavior	January 2019	41				0.50	Negative I	Septembe	ZZZ	0.5	0.14	0.07	0.02		FALSE			FALSE		Septembe	40	Complete	TRUE	Increase
96164	Health behavic	Health and Behavior	January 2019	41				0.21	Negative I	Septembe	XXX	0.21	0.06	0.03	0.01		FALSE			FALSE		Septembe	40	Complete	TRUE	Increase
96165	Health behavic	Health and Behavior	January 2019	41				0.10	Negative I	Septembe	ZZZ	0.1	0.03	0.01	0.00		FALSE			FALSE		Septembe	40	Complete	TRUE	Increase
96167	Health behavic	Health and Behavior	January 2019	41				1.55	Negative I	Septembe	XXX	1.55	0.44	0.20	0.05		FALSE			FALSE		Septembe	40	Complete	TRUE	Increase
96168	Health behavic	Health and Behavior	January 2019	41				0.55	Negative I	Septembe	ZZZ	0.55	0.16	0.07	0.02		FALSE			FALSE		Septembe	40	Complete	TRUE	Increase
96170	Health behavic	Health and Behavior	January 2019	41				1.50	Negative I	Septembe	XXX	1.5	0.71	0.58	0.13		FALSE			FALSE		Septembe	40	Complete	TRUE	Increase
96171	Health behavic	Health and Behavior	January 2019	41				0.54	Negative I	Septembe	ZZZ	0.54	0.26	0.21	0.04		FALSE			FALSE		Septembe	40	Complete	TRUE	Increase
96360	Intravenous in	IV Hydration	January 2017	25			ASCO, ASH	0.17	CMS High	July 2015	XXX	0.17	0.85	NA	0.02	248266	FALSE			TRUE	These services were iden	N/A	N/A	N/A	TRUE	Maintain
96361	Intravenous in	IV Hydration	January 2017	25			ASCO, ASH	0.09	CMS High	July 2015	ZZZ	0.09	0.30	NA	0.01	433535	FALSE			TRUE	These services were iden	N/A	N/A	N/A	TRUE	Maintain
96365	Intravenous in	Intravenous Infusior	January 2013	28			ACRh, ASC	0.21	CMS High	Septembe	XXX	0.21	1.86	NA	0.04	1269889	FALSE			FALSE					TRUE	Maintain
96366	Intravenous in	Intravenous Infusior	January 2013	28			ACRh, ASC	0.18	CMS High	April 2013	ZZZ	0.18	0.45	NA	0.01	558744	FALSE			FALSE					TRUE	Maintain
96367	Intravenous in	Intravenous Infusior	January 2013	28			ACRh, ASC	0.19	CMS High	Septembe	ZZZ	0.19	0.71	NA	0.02	1292846	FALSE			FALSE					TRUE	Maintain
96368	Intravenous in	Intravenous Infusior	January 2013	28			ACRh, ASC	0.17	CMS High	April 2013	ZZZ	0.17	0.43	NA	0.01	133379	FALSE			FALSE					TRUE	Maintain
96372	Therapeutic, p	Application of On-bc	January 2017	26			ASCO, ASH	0.17	Different F	April 2013	XXX	0.17	0.23	NA	0.01	9458412	FALSE			TRUE	These services were iden	N/A	N/A	N/A	TRUE	Maintain
96374	Therapeutic, p	Application of On-bc	January 2017	26			ASCO, ASH	0.18	CMS High	July 2015	XXX	0.18	1.00	NA	0.02	272442	FALSE			TRUE	These services were iden	N/A	N/A	N/A	TRUE	Maintain
96375	Therapeutic, p	Application of On-bc	January 2017	26			ASCO, ASH	0.10	CMS High	July 2015	ZZZ	0.1	0.38	NA	0.01	1416745	FALSE			TRUE	These services were iden	N/A	N/A	N/A	TRUE	Maintain
96377	Application of	Application of On-bc	January 2017	26			ASCO, ASH	0.17	should be	January 20	XXX	0.17	0.40	NA	0.01	60948	FALSE			FALSE	Other family of services w	N/A	N/A	N/A	TRUE	Not Part of RAW
96401	Chemotherapy	Chemotherapy Adm	January 2017	27			ASBMT, AS	0.21	CMS High	July 2015	XXX	0.21	2.10	NA	0.05	758701	FALSE			TRUE	These services were iden	N/A	N/A	N/A	TRUE	Maintain
96402	Chemotherapy	Chemotherapy Adm	January 2017	27			ASBMT, AS	0.19	CMS High	July 2015	XXX	0.19	0.74	NA	0.02	403494	FALSE			TRUE	These services were iden	N/A	N/A	N/A	TRUE	Maintain
96405	Chemotherapy	Chemotherapy Adm	April 2008	55			ASCO	New PE in	CMS Requ	NA	000	0.52	1.95	0.28	0.04	12359	FALSE			FALSE					TRUE	PE Only
96406	Chemotherapy	Chemotherapy Adm	April 2008	55			ASCO	New PE in	CMS Requ	NA	000	0.8	3.05	0.45	0.05	566	FALSE			FALSE					TRUE	PE Only
96409	Chemotherapy	Chemotherapy Adm	January 2017	27			ASBMT, AS	0.24	CMS High	July 2015	XXX	0.24	2.95	NA	0.06	79884	FALSE			TRUE	These services were iden	N/A	N/A	N/A	TRUE	Maintain
96411	Chemotherapy	Chemotherapy Adm	January 2017	27			ASBMT, AS	0.20	CMS High	July 2015	ZZZ	0.2	1.54	NA	0.04	165078	FALSE			TRUE	These services were iden	N/A	N/A	N/A	TRUE	Maintain
96413	Chemotherapy	Chemotherapy Adm	January 2013	29			ACRh, ASC	0.28 and n	Codes Rep	February 2	XXX	0.28	3.88	NA	0.09	1875219	FALSE			FALSE					TRUE	Maintain
96415	Chemotherapy	Chemotherapy Adm	January 2013	29			ACRh, ASC	0.19 and n	CMS High	January 20	ZZZ	0.19	0.69	NA	0.02	891855	FALSE			FALSE					TRUE	Maintain
96416	Chemotherapy	Chemotherapy Adm	October 2010	20			ACRh, ASC	New PE in	Codes Rep	February 2	XXX	0.21	3.92	NA	0.09	30942	FALSE			FALSE					TRUE	PE Only
96417	Chemotherapy	Chemotherapy Adm	January 2013	29			ACRh, ASC	0.21 and n	CMS High	January 20	ZZZ	0.21	1.81	NA	0.04	388626	FALSE			FALSE					TRUE	Maintain
96440	Chemotherapy	Chemotherapy Adm	February 2008	R				New PE in	CMS Requ	NA	000	2.12	25.94	1.00	0.48	60	FALSE			FALSE					TRUE	PE Only
96567	Photodynamic	Photodynamic Thera	January 2017	16			AAD	0.00 PE Or	High Volur	February 2	XXX	0	4.24	NA	0.01	66951	FALSE			TRUE	CPT code 96567 Photody	Septembe	78	yes	TRUE	Maintain
96573	Photodynamic	Photodynamic Thera	January 2017	16			AAD	0.48	CMS High	January 20	000	0.48	6.40	NA	0.02	39219	FALSE			FALSE		Septembe	78	yes	TRUE	Increase
96574	Debridement (	Photodynamic Thera	January 2017	16			AAD	1.01	CMS High	January 20	000	1.01	7.44	NA	0.04	48673	FALSE			FALSE		Septembe	78	yes	TRUE	Increase
96910	Photochemoth	Photo-chemotherap	April 2016	44			AAD	PE Only	CMS High	July 2015	XXX	0	3.48	NA	0.02	386553	FALSE			FALSE					TRUE	PE Only
96920	Laser treatmer	Laser Treatment – Sl	October 2019	17	January 20	RAW	AAD	1.15. Revie	CMS Faste	October 20	000	1.15	3.56	0.66	0.05	118570	TRUE	Sep 2016	Yes	FALSE					TRUE	Maintain
96921	Laser treatmer	Laser Treatment – Sl	October 2019	17	January 20	RAW	AAD	1.30. Revie	High Volur	February 2	000	1.3	3.85	0.74	0.05	29878	TRUE	Sep 2016	Yes	FALSE					TRUE	Increase
96922	Laser treatmer	Laser Treatment – Sl	October 2019	17	January 20	RAW	AAD	2.10. Revie	High Volur	October 20	000	2.1	4.86	1.19	0.09	15528	TRUE	Sep 2016	Yes	FALSE					TRUE	Maintain
97001	Physical thera	Physical Medicine ar	October 2015	17		HCPAC		Deleted fr	CMS High	September 2011							FALSE			TRUE	In Jan 2012, the specialty	February 2	88	Complete	TRUE	Deleted from CPT
97002	Physical thera	Physical Medicine ar	October 2015	17		HCPAC		Deleted fr	CMS High	February 2015							FALSE			FALSE		February 2	88	Complete	TRUE	Deleted from CPT
97003	Occupational t	Physical Medicine ar	October 2015	17		HCPAC		Deleted fr	CMS High	February 2015							FALSE			FALSE		February 2	88	Complete	TRUE	Deleted from CPT
97004	Occupational t	Physical Medicine ar	October 2015	17		HCPAC		Deleted fr	CMS High	February 2015							FALSE			FALSE		February 2	88	Complete	TRUE	Deleted from CPT
97010	Application of	Physical Medicine ar	April 2017	41			No Interes	No special	Physical M	April 2016	XXX	0.06	0.11	NA	0.01		FALSE			FALSE					TRUE	Maintain
97012	Application of	Physical Medicine ar	January 2017	29			APTA	0.25	Physical M	April 2016	XXX	0.25	0.17	NA	0.01	560317	FALSE			FALSE	In February 2010, Physical Medicine and Rehab			survey exist	TRUE	Maintain
97014	Application of	Physical Medicine ar	January 2017	29			APTA	0.18	Physical M	April 2016	XXX	0.18	0.20	NA	0.01		FALSE			FALSE	In February 2010, Physical Medicine and Rehab			survey exist	TRUE	Maintain
97016	Application of	Physical Medicine ar	January 2017	29			APTA	0.18	Codes Rep	February 2	XXX	0.18	0.16	NA	0.01	864521	FALSE			FALSE	In February 2010, Physical Medicine and Rehab			survey exist	TRUE	Maintain
97018	Application of	Physical Medicine ar	January 2017	29			AOTA, APT	0.06	Codes Rep	February 2	XXX	0.06	0.10	NA	0.01	174530	FALSE			FALSE	In February 2010, Physical Medicine and Rehab			survey exist	TRUE	Maintain
97022	Application of	Physical Medicine ar	January 2017	29			APTA	0.17	Physical M	April 2016	XXX	0.17	0.34	NA	0.01	193036	FALSE			FALSE	In February 2010, Physical Medicine and Rehab			survey exist	TRUE	Maintain
97032	Application of	Physical Medicine ar	January 2017	29			APTA	0.25	CMS High	July 2015	XXX	0.25	0.17	NA	0.01	849666	FALSE			FALSE	In February 2010, Physical Medicine and Rehab			survey exist	TRUE	Maintain
97033	Application of	Physical Medicine ar	January 2017	29			APTA	0.26	Physical M	April 2016	XXX	0.26	0.32	NA	0.01	56451	FALSE			FALSE	In February 2010, Physical Medicine and Rehab			survey exist	TRUE	Maintain
97034	Application of	Physical Medicine ar	January 2017	29			APTA, AOT	0.21	Physical M	April 2016	XXX	0.21	0.21	NA	0.01	8235	FALSE			FALSE	In February 2010, Physical Medicine and Rehab			survey exist	TRUE	Maintain
97035	Application of	Physical Medicine ar	January 2017	29			APTA	0.21	Low Value	October 20	XXX	0.21	0.20	NA	0.01	2002641	FALSE			FALSE	In February 2010, Physical Medicine and Rehab			survey exist	TRUE	Maintain
97110	Therapeutic pr	Physical Medicine ar	January 2017	29			AOTA, APT	0.45	Codes Rep	February 2	XXX	0.45	0.40	NA	0.02	60569850	FALSE			FALSE	In April 2016, the Relativity Assessment Workg			survey exist	TRUE	Maintain
97112	Therapeutic pr	Physical Medicine ar	January 2017	29			APTA, AOT	0.50	CMS High	Septembe	XXX	0.5	0.49	NA	0.02	18084367	FALSE			FALSE	In April 2016, the Relativity Assessment Workg			survey exist	TRUE	Increase
97113	Therapeutic pr	Physical Medicine ar	January 2017	29			APTA	0.48	CMS High	July 2015	XXX	0.48	0.60	NA	0.02	1811269	FALSE			FALSE	In April 2016, the Relativity Assessment Workg			survey exist	TRUE	Increase

97116	Therapeutic pr	Physical Medicine ar	January 2017	29			APTA	0.45	Codes Rep	February 2	XXX	0.45	0.40	NA	0.02	2661789	FALSE			FALSE	In April 2016, the Relativity Assessment Workg			survey exist	TRUE	Increase
97127	Therapeutic in	Cognitive Function Ir	January 2017	29				1.50	High Volur	January 2017							FALSE			FALSE		Septembe	80	yes	TRUE	Decrease
97140	Manual therap	Physical Medicine ar	January 2017	29			APTA	0.43	CMS High	Septembe	XXX	0.43	0.35	NA	0.02	29711740	FALSE			FALSE	In April 2016, the Relativity Assessment Workg			survey exist	TRUE	Maintain
97150	Therapeutic pr	Physical Medicine ar	January 2012				APTA	0.29	CMS-Othe	April 2011	XXX	0.29	0.22	NA	0.01	1433348	FALSE			FALSE				survey exist	TRUE	Increase
97161	Physical thera	Physical Medicine ar	October 2015	17		HCPAC	AOTA, APT	0.75	CMS High	February 2	XXX	1.54	1.33	NA	0.05	1552998	FALSE			FALSE		February 2	88	Complete	TRUE	Decrease
97162	Physical thera	Physical Medicine ar	October 2015	17		HCPAC	AOTA, APT	1.18	CMS High	February 2	XXX	1.54	1.33	NA	0.05	1386353	FALSE			FALSE		February 2	88	Complete	TRUE	Decrease
97163	Physical thera	Physical Medicine ar	October 2015	17		HCPAC	AOTA, APT	1.50	CMS High	February 2	XXX	1.54	1.33	NA	0.05	318604	FALSE			FALSE		February 2	88	Complete	TRUE	Maintain
97164	Re-evaluation	Physical Medicine ar	October 2015	17		HCPAC	AOTA, APT	0.75	CMS High	February 2	XXX	0.96	1.00	NA	0.04	585829	FALSE			FALSE		February 2	88	Complete	TRUE	Increase
97165	Occupational t	Physical Medicine ar	October 2015	17		HCPAC	AOTA, APT	0.88	CMS High	February 2	XXX	1.54	1.24	NA	0.05	146443	FALSE			FALSE		February 2	88	Complete	TRUE	Decrease
97166	Occupational t	Physical Medicine ar	October 2015	17		HCPAC	AOTA, APT	1.20	CMS High	February 2	XXX	1.54	1.24	NA	0.05	101883	FALSE			FALSE		February 2	88	Complete	TRUE	Maintain
97167	Occupational t	Physical Medicine ar	October 2015	17		HCPAC	AOTA, APT	1.70	CMS High	February 2	XXX	1.54	1.24	NA	0.05	22637	FALSE			FALSE		February 2	88	Complete	TRUE	Increase
97168	Re-evaluation	Physical Medicine ar	October 2015	17		HCPAC	AOTA, APT	0.80	CMS High	February 2	XXX	0.96	0.91	NA	0.04	33480	FALSE			FALSE		February 2	88	Complete	TRUE	Increase
97530	Therapeutic ac	Physical Medicine ar	January 2017	29			APTA, AOT	0.44	CMS High	Septembe	XXX	0.44	0.67	NA	0.02	20151706	FALSE			FALSE	In April 2016, the Relativity Assessment Workg			survey exist	TRUE	Maintain
97532	Development (	Cognitive Function Ir	January 2017	29			APTA, AOT	Deleted fr	High Volur	April 2013							FALSE			TRUE	In April 2016 the Relativit	Septembe	80	yes	TRUE	Deleted from CPT
97533	Sensory integr	Physical Medicine ar	January 2017	29			APTA, AOT	0.48	Physical M	April 2016	XXX	0.48	1.24	NA	0.02	21250	FALSE			FALSE	In April 2016 the Relativity Assessment Workgr			survey exist	TRUE	Increase
97535	Self-care/hom	Physical Medicine ar	January 2017	29			APTA, AOT	0.45	Codes Rep	October 2(	XXX	0.45	0.50	NA	0.02	1942480	TRUE	Article no	Yes	FALSE	In April 2016 the Relativity Assessment Workgr			survey exist	TRUE	Maintain
97537	Community/w	Physical Medicine ar	January 2017	29			APTA, AOT	0.48	Physical M	April 2016	XXX	0.48	0.43	NA	0.02	23275	FALSE			FALSE	In April 2016 the Relativity Assessment Workgr			survey exist	TRUE	Increase
97542	Wheelchair ma	Physical Medicine ar	January 2017	29			APTA, AOT	0.48	High Volur	April 2013	XXX	0.48	0.44	NA	0.02	61278	FALSE			FALSE	In April 2016, the Relativity Assessment Workg			survey exist	TRUE	Increase
97597	Debridement (	Open Wound Debric	October 2018	23			AAFP, ACS	0.88	Site of Ser	Septembe	000	0.77	2.12	0.22	0.05	897614	FALSE			TRUE	In January 2018, the RUC recommended that 9			N/A	TRUE	Increase
97598	Debridement (	Open Wound Debric	October 2018	23			AAFP, ACS	0.50	Site of Ser	Septembe	ZZZ	0.5	0.79	0.18	0.05	135670	FALSE			TRUE	In January 2018, the RUC recommended that 9			N/A	TRUE	Increase
97602	Removal of de	Physical Medicine ar	April 2016	47			AAOS, ACS	Maintain	Physical M	April 2016	XXX	0	0.00	0.00	0.00		FALSE			FALSE					TRUE	Maintain
97605	Negative press	Negative Pressure W	April 2016	47			AAOS, ACS	0.55	High Volur	April 2013	XXX	0.55	0.67	0.16	0.02	51268	FALSE			FALSE					TRUE	Maintain
97606	Negative press	Negative Pressure W	April 2016	47			APMA, AC	0.60	High Volur	April 2013	XXX	0.6	0.85	0.18	0.02	15612	FALSE			FALSE					TRUE	Maintain
97607	Negative press	Negative Pressure W	April 2016	47			APMA, AC	0.11	High Volur	May 2013	XXX	0.41	9.58	0.17	0.09	5825	FALSE			FALSE					TRUE	Decrease
97608	Negative press	Negative Pressure W	April 2016	47			APMA, AC	0.46	High Volur	May 2013	XXX	0.46	9.26	0.19	0.09	1172	FALSE			FALSE					TRUE	Decrease
97610	Low frequency	Physical Medicine ar	April 2016	47				Maintain	Physical M	April 2016	XXX	0.4	11.52	0.12	0.01	12331	FALSE			FALSE					TRUE	Maintain
97755	Assistive techr	Physical Medicine ar	April 2016	47			APTA, AOT	Remove fr	High Volur	February 2	XXX	0.62	0.47	NA	0.02	2693	FALSE			FALSE					TRUE	Remove from screen
97760	Orthotic(s) ma	Orthotic Manageme	January 2017	29			APTA, AOT	0.50	Physical M	April 2016	XXX	0.5	0.92	NA	0.02	57907	FALSE			TRUE	In April 2016 the RAW rev	Septembe	81	yes	TRUE	Increase
97761	Prosthetic(s) tr	Orthotic Manageme	January 2017	29			APTA	0.50	Physical M	April 2016	XXX	0.5	0.70	NA	0.02	2698	FALSE			TRUE	In April 2016 the RAW rev	Septembe	81	yes	TRUE	Increase
97762	Checkout for o	Orthotic Manageme	January 2017	29			APTA	Deleted fr	Physical M	April 2016							FALSE			TRUE	In April 2016 the RAW rev	Septembe	81	yes	TRUE	Deleted from CPT
97763	Orthotic(s)/pro	Orthotic Manageme	January 2017	29			APTA, AOT	0.48	Physical M	April 2016	XXX	0.48	1.08	NA	0.02	38754	FALSE			FALSE					TRUE	Increase
97802	Medical nutriti	Medical Nutrition Th	April 2008	53			ADA, AGA,	0.53	CMS Requ	NA	XXX	0.53	0.53	0.40	0.02	224711	FALSE			FALSE					TRUE	Increase
97803	Medical nutriti	Medical Nutrition Th	April 2008	53			ADA, AGA,	0.45	CMS Requ	NA	XXX	0.45	0.46	0.34	0.02	211418	FALSE			FALSE					TRUE	Increase
98925	Osteopathic m	Osteopathic Manipu	February 2011	34			AOA	0.50	Harvard Va	February 2	000	0.46	0.42	0.20	0.04	65014	FALSE			FALSE					TRUE	Increase
98926	Osteopathic m	Osteopathic Manipu	February 2011	34			AOA	0.75	Harvard Va	October 2(	000	0.71	0.55	0.28	0.04	109622	FALSE			FALSE					TRUE	Increase
98927	Osteopathic m	Osteopathic Manipu	February 2011	34			AOA	1.00	Harvard Va	October 2(	000	0.96	0.69	0.35	0.05	99716	FALSE			FALSE					TRUE	Increase
98928	Osteopathic m	Osteopathic Manipu	February 2011	34			AOA	1.25	Harvard Va	February 2	000	1.21	0.81	0.44	0.05	99045	FALSE			FALSE					TRUE	Increase
98929	Osteopathic m	Osteopathic Manipu	February 2011	34			AOA	1.50	Harvard Va	February 2	000	1.46	0.94	0.53	0.09	76576	FALSE			FALSE					TRUE	Increase
98940	Chiropractic m	Chiropractic Manipu	October 2012	25			ACA	0.46	CMS High	Septembe	000	0.46	0.34	0.17	0.01	5600246	FALSE			FALSE					TRUE	Increase
98941	Chiropractic m	Chiropractic Manipu	October 2012	25			ACA	0.71	CMS High	Septembe	000	0.71	0.44	0.26	0.01	13626398	FALSE			FALSE					TRUE	Increase
98942	Chiropractic m	Chiropractic Manipu	October 2012	25			ACA	0.96	CMS High	Septembe	000	0.96	0.54	0.36	0.02	948986	FALSE			FALSE					TRUE	Increase
98943	Chiropractic m	Chiropractic Manipu	October 2012	25			ACA	0.46	CMS High	Septembe	XXX	0.46	0.29	0.18	0.04		FALSE			FALSE					TRUE	Increase
99143	Deleted from (	Moderate Sedation !	October 2015	14		RUC	AAP, AAOI	Deleted fr	Moderate	January 2014							FALSE			FALSE					TRUE	Deleted from CPT
99144	Deleted from (	Moderate Sedation !	October 2015	14		RUC	AAP, AAOI	Deleted fr	Moderate	January 2014							FALSE			FALSE					TRUE	Deleted from CPT
99148	Deleted from (	Moderate Sedation !	October 2015	14		RUC	AAP, AAOI	Deleted fr	Moderate	January 2014							FALSE			FALSE					TRUE	Deleted from CPT
99149	Deleted from (	Moderate Sedation !	October 2015	14		RUC	AAP, AAOI	Deleted fr	Moderate	January 2014							FALSE			FALSE					TRUE	Deleted from CPT
99150	Deleted from (	Moderate Sedation !	October 2015	14		RUC	AAP, AAOI	Deleted fr	Moderate	January 2014							FALSE			FALSE					TRUE	Deleted from CPT
99151	Moderate seda	Moderate Sedation !	October 2015	14		RUC	AAP, AAOI	0.50	Moderate	January 20	XXX	0.5	1.99	0.18	0.05	11	FALSE			FALSE					TRUE	Maintain
99152	Moderate seda	Moderate Sedation !	October 2015	14		RUC	AAP, AAOI	0.25	Moderate	January 20	XXX	0.25	1.24	0.09	0.02	1909615	FALSE			FALSE					TRUE	Maintain
99155	Moderate seda	Moderate Sedation !	October 2015	14		RUC	AAP, AAOI	1.90	Moderate	January 20	XXX	1.9	NA	0.32	0.21	30	FALSE			FALSE					TRUE	Maintain
99156	Moderate seda	Moderate Sedation !	October 2015	14		RUC	AAP, AAOI	1.84	Moderate	January 20	XXX	1.65	NA	0.41	0.16	7955	FALSE			FALSE					TRUE	Maintain
99174	Instrument-ba	Instrument-Based O	September 201	09			AAP, AAO	PE Only	CMS Requ	NA	XXX	0	0.15	NA	0.01		FALSE			TRUE	CMS requested a review (	May 2014	24	Complete	TRUE	PE Only
99177	Instrument-ba	Instrument-Based O	September 201	09				PE Only	CMS Requ	May 2014	XXX	0	0.12	NA	0.01		FALSE			TRUE		May 2014	24	Complete	TRUE	PE Only
99183	Physician or ot	Hyperbaric Oxygen T	January 2014	33			ACEP, ACP	2.11	CMS-Othe	April 2013	XXX	2.11	0.78	0.78	0.26	386280	FALSE			FALSE					TRUE	Decrease
99281	Emergency de	ED Visits	April 2018	29			AAP, ACEP	0.48	CMS Requ	June 2017	XXX	0.48	NA	0.11	0.05	67730	FALSE			FALSE					TRUE	Increase
99282	Emergency de	ED Visits	April 2018	29			AAP, ACEP	0.93	CMS Requ	June 2017	XXX	0.93	NA	0.21	0.10	352496	FALSE			FALSE					TRUE	Increase
99283	Emergency de	ED Visits	April 2018	29			AAP, ACEP	1.42	CMS Requ	June 2017	XXX	1.6	NA	0.33	0.16	2744710	FALSE			FALSE					TRUE	Increase
99284	Emergency de	ED Visits	April 2018	29			AAP, ACEP	2.60	CMS Requ	June 2017	XXX	2.74	NA	0.54	0.27	5415650	FALSE			FALSE					TRUE	Increase
99285	Emergency de	ED Visits	April 2018	29			AAP, ACEP	3.80	CMS Requ	June 2017	XXX	4	NA	0.75	0.43	11514274	FALSE			FALSE					TRUE	Maintain
99358	Prolonged eva	Prolonged Services -	October 2021	14			AAFP, AAH	1.80	CMS Requ	November	XXX	2.1	0.95	0.95	0.15	211314	FALSE			TRUE	In October 2020, the RUC	February 2	11	complete	TRUE	Decrease
99359	Prolonged eva	Prolonged Services -	October 2021	14			AAFP, AAH	0.75	CMS Requ	November	ZZZ	1	0.47	0.47	0.06	7861	FALSE			TRUE	In October 2020, the RUC	February 2	11	complete	TRUE	Decrease
99363	Anticoagulant	Home INR Monitorir	January 2017	19				Deleted fr	High Volur	September 2016							FALSE			FALSE		Septembe	08	yes	TRUE	Deleted from CPT
99364	Anticoagulant	Home INR Monitorir	January 2017	19				Deleted fr	High Volur	September 2016							FALSE			FALSE		Septembe	08	yes	TRUE	Deleted from CPT
99375	Supervision of	Home Healthcare Su	April 2016	47			No Interes	RUC recon	CMS-Othe	April 2016	XXX	1.73	1.13	0.67	0.14		FALSE			FALSE					TRUE	Remove from screen
99378	Supervision of	Home Healthcare Su	April 2016	47			No Interes	RUC recon	CMS-Othe	April 2016	XXX	1.73	1.13	0.67	0.14		FALSE			FALSE					TRUE	Remove from screen
99415	Prolonged clin	Prolonged Services -	April 2021	15			AAHPM, A	New PE In	CMS Request - Final F		ZZZ	0	0.28	NA	0.01	4248	FALSE			TRUE	In October 2020, the RUC	February 2022			TRUE	PE Only
99416	Prolonged clin	Prolonged Services -	April 2021	15			AAHPM, A	New PE In	CMS Request - Final F		ZZZ	0	0.15	NA	0.00	1382	FALSE			TRUE	In October 2020, the RUC	February 2022			TRUE	PE Only
99417	Prolonged offi	Prolonged Services -	January 2022		January 20	RUC	AAFP, AAH	Survey	CMS Requ	November	XXX	0	0.00	0.00	0.00		FALSE			FALSE	In October 2020, the RUC	February 2	11	complete	FALSE	
99491	Chronic care m	Chronic Care Manag	April 2017	09			AAFP, AAN	1.45. Refe	New and F	NA	XXX	1.45	0.82	0.82	0.09	48091	TRUE	Oct 2018	yes	FALSE					TRUE	Not part of RAW
99492	Initial psychiat	Psychiatric Collabora	January 2020	37	October 2(	RAW	AACAP, AA	CMS inves	Work Neu	October 2(	XXX	1.88	2.41	0.68	0.13	16445	FALSE			FALSE					FALSE	
99493	Subsequent ps	Psychiatric Collabora	January 2020	37	October 2(	RAW	AACAP, AA	CMS inves	Work Neu	October 2(	XXX	2.05	2.24	0.76	0.13	14660	FALSE			FALSE					FALSE	
99494	Initial or subse	Psychiatric Collabora	January 2020	37	October 2(	RAW	AACAP, AA	CMS inves	Work Neu	October 2(	ZZZ	0.82	0.82	0.30	0.05	27335	FALSE			FALSE					FALSE	
99497	Advance care p	Advance Care Planni	October 2019	17	January 20	RAW	AAFP, AAN	Review in	RUC Refer	January 20	XXX	1.5	0.86	0.65	0.10	1825276	TRUE	Dec 2014	Yes	FALSE					FALSE	
99498	Advance care p	Advance Care Planni	October 2019	17	January 20	RAW	AAFP, AAN	Review in	RUC Refer	January 20	ZZZ	1.4	0.64	0.63	0.09	60204	TRUE	Dec 2014	Yes	FALSE					FALSE	
0191T	Insertion of an	Cataract Removal wi	January 2021	16			AAO	Deleted fr	High Volur	October 2(	XXX	0	0.00	0.00	0.00	57829	FALSE			TRUE	At the April 2019 RUC me	October 2(	37	complete	TRUE	Deleted from CPT
0275T	Percutaneous laminotomy/laminec		January 2020	37				Maintain	High Volur	October 2(	YYY	0	0.00	0.00	0.00	2656	FALSE			FALSE					TRUE	Maintain
0376T	Insertion of an	Cataract Removal wi	January 2021	16			AAO	Deleted fr	High Volur	October 2(	XXX	0	0.00	0.00	0.00	16708	FALSE			TRUE	At the April 2019 RUC me	October 2(	37	complete	TRUE	Deleted from CPT
0379T	Visual field assessment, with concu		January 2020	37	October 2(	RAW		Review in	High Volur	October 2(	XXX	0	0.00	0.00	0.00	49050	FALSE			FALSE					FALSE	
0394T	High dose rate electronic brachythe		January 2020	37	October 2(	RAW		Review in	High Volur	October 2(	XXX	0	0.00	0.00	0.00	28857	FALSE			FALSE					FALSE	
0446T	Creation of sul	Insertion/ Removal (	January 2020	33			AACE, ES	Contractor	CMS Requ	November	000	1.14	53.70	0.44	0.09		FALSE			TRUE	In the CY 2020 Final Rule,	February 2	46	Renewed 5	TRUE	Contractor Price

0447T	Removal of im	Insertion/ Removal (	January 2020	33			AACE, ES	Contractor	CMS Requ	November	000	1.34	1.55	0.52	0.11		FALSE		TRUE	In the CY 2020 Final Rule, February	246	Renewed 5		TRUE	Contractor Price
0448T	Removal of im	Insertion/ Removal (	January 2020	33			AACE, ES	Contractor	CMS Requ	November	000	1.91	53.16	0.74	0.15		FALSE		TRUE	In the CY 2020 Final Rule, February	246	Renewed 5		TRUE	Contractor Price
0449T	Insertion of aqueous drainage devi		January 2020	37				Maintain	High Volur	October 2(	YYY	0	0.00	0.00	0.00	5679	FALSE		FALSE					TRUE	Maintain
0474T	Insertion of anterior segment aque		January 2020	37				Maintain	High Volur	October 2(	XXX	0	0.00	0.00	0.00	12	FALSE		FALSE					TRUE	Maintain
0509T	Electroretinog	Electroretinography	January 2021	29	January 2(	RAW		Review ac	Work Neu	October 2(	XXX	0.4	1.84	NA	0.02	41106	FALSE		FALSE					FALSE	Remove from Screen
0671T	Insertion of an	Cataract Removal wi	January 2021	16			AAO	Contractor	High Volur	January 2021							FALSE		FALSE	At the April 2019 RUC me	October 2(	37	complete	TRUE	Contractor Price
15778		Anterior Abdominal	April 2021	09			ACS, ASCR	8.00	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49591		Anterior Abdominal	April 2021	09			ACS, ASCR	6.27	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49592		Anterior Abdominal	April 2021	09			ACS, ASCR	9.00	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49593		Anterior Abdominal	April 2021	09			ACS, ASCR	10.80	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49594		Anterior Abdominal	April 2021	09			ACS, ASCR	14.00	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49595		Anterior Abdominal	April 2021	09			ACS, ASCR	14.88	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49596		Anterior Abdominal	April 2021	09			ACS, ASCR	20.00	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49613		Anterior Abdominal	April 2021	09			ACS, ASCR	7.75	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49614		Anterior Abdominal	April 2021	09			ACS, ASCR	10.79	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49615		Anterior Abdominal	April 2021	09			ACS, ASCR	12.00	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49616		Anterior Abdominal	April 2021	09			ACS, ASCR	16.50	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49617		Anterior Abdominal	April 2021	09			ACS, ASCR	16.97	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49618		Anterior Abdominal	April 2021	09			ACS, ASCR	24.00	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49621		Anterior Abdominal	April 2021	09			ACS, ASCR	14.24	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49622		Anterior Abdominal	April 2021	09			ACS, ASCR	18.00	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
49623		Anterior Abdominal	April 2021	09			ACS, ASCR	5.00	Site of Ser	February 2021							FALSE		FALSE	In October 2019, the Rela	February 2	18	complete	TRUE	Decrease
92066		Orthoptic Training	April 2021	10			AAO, AOA	New PE In	Harvard V	February 2021							FALSE		FALSE					TRUE	PE Only
96202		Caregiver Behavior M	April 2021	11	October 2(	RAW	AACAP, AN	Review ac	RUC Flag fi	April 2021							FALSE		FALSE					FALSE	Not part of RAW
96203		Caregiver Behavior M	April 2021	11	October 2(	RAW		Review ac	RUC Flag fi	April 2021							FALSE		FALSE					FALSE	Not part of RAW
99418		Prolonged Services -	January 2022		January 2(	RUC	AAHPM, A	Survey	CMS Requ	February 2021							FALSE		FALSE	In October 2020, the RUC	February 2	11	complete	FALSE	
G0008	Administratior	Immunization Admir	April 2021	19			AAFP, AAP	0.17	CMS Requ	July 2020	XXX	0	0.00	0.00	0.00		FALSE		FALSE					TRUE	Maintain
G0009	Administratior	Immunization Admir	April 2021	19			AAFP, AAP	0.17	CMS Requ	July 2020	XXX	0	0.00	0.00	0.00		FALSE		FALSE					TRUE	Maintain
G0010	Administratior	Immunization Admir	April 2021	19			AAFP, AAP	0.17	CMS Requ	July 2020	XXX	0	0.00	0.00	0.00		FALSE		FALSE					TRUE	Maintain
G0101	Cervical or vaginal cancer screening		October 2016	35			ACOG	Remove fr	Low Value	October 2(	XXX	0.45	0.63	0.29	0.06	929962	FALSE		FALSE					TRUE	Remove from Screen
G0102	Prostate cance	RAW	January 2017	30				Remove fr	High Volur	October 2(	XXX	0.18	0.47	0.07	0.01	30358	FALSE		FALSE					TRUE	Remove from screen
G0104	Colorectal can	Flexible Sigmoidosc	January 2014	09			AGA, ASGE	0.84	MPC List	January 2(	000	0.84	4.65	0.67	0.11	2724	FALSE		FALSE		October 2(	16	Complete	TRUE	Decrease
G0105	Colorectal can	Colonoscopy	January 2014	10			AGA, ASGE	3.36	MPC List	Septembe	000	3.26	6.56	1.73	0.41	262478	FALSE		FALSE					TRUE	Decrease
G0108	Diabetes outpa	Diabetes Manageme	April 2017	41iv			AND	0.90	CMS-Othe	April 2016	XXX	0.9	0.66	NA	0.05	172612	FALSE		FALSE					TRUE	Maintain
G0109	Diabetes outpa	Diabetes Manageme	April 2017	41iv			AND	0.25	CMS-Othe	April 2016	XXX	0.25	0.19	NA	0.01	111248	FALSE		FALSE					TRUE	Maintain
G0121	Colorectal can	Colonoscopy	January 2014	10			AGA, ASGE	3.36	MPC List	Septembe	000	3.26	6.56	1.73	0.42	215409	FALSE		FALSE					TRUE	Decrease
G0124	Screening cyto	Cytopathology Cervi	April 2018	26			CAP	0.42	CMS-Othe	October 2(	XXX	0.26	0.36	0.36	0.01	47978	FALSE		FALSE					TRUE	Maintain
G0127	Trimming of dystrophic nails, any n		September 201	51			APMA	Remove fr	CMS-Othe	April 2011	000	0.17	0.52	0.04	0.01	1109311	FALSE		FALSE					TRUE	Remove from Screen
G0141	Screening cyto	Cytopathology Cervi	April 2018	26			CAP	0.42	CMS-Othe	October 2(	XXX	0.26	0.36	0.36	0.01	3666	FALSE		FALSE					TRUE	Maintain
G0166	External count	External Counterpul	October 2019	14			ACC	0.00 (PE O	CMS-Othe	April 2016	XXX	0	3.35	NA	0.04	95502	FALSE		FALSE					TRUE	PE Only
G0168	Wound closure	Wound Closure by A	April 2017	34			ACEP, AAF	0.45	CMS 000-D	July 2016	000	0.31	3.20	0.08	0.05	44921	FALSE		FALSE					TRUE	Maintain
G0179	Physician re-ce	Physician Recertifica	April 2016	47			No Interes	RUC recon	CMS Faste	October 2(	XXX	0.45	0.70	NA	0.04	806300	FALSE		FALSE	The Workgroup asked CMS why G codes are developed. CM				TRUE	Remove from screen
G0180	Physician certi	Physician Recertifica	April 2016	47			No Interes	RUC recon	CMS Faste	October 2(	XXX	0.67	0.81	NA	0.05	1169998	FALSE		FALSE	The Workgroup asked CMS why G codes are developed. CM				TRUE	Remove from screen
G0181	Physician supe	Home Healthcare Su	April 2016	47			No Interes	Recomme	CMS Faste	October 2(	XXX	1.73	1.21	NA	0.11	386948	FALSE		FALSE	The Workgroup asked CMS why G codes are developed. CM				TRUE	Remove from screen
G0182	Physician supe	Home Healthcare Su	April 2016	47			No Interes	Recomme	CMS-Othe	April 2016	XXX	1.73	1.25	NA	0.11	26148	FALSE		FALSE					TRUE	Remove from screen
G0202	Screening mar	Mammography	January 2016	20			ACR	Assume CI	CMS Faste	February 2008							FALSE		TRUE	In the NPRM for 2015, CM	October 2(	38	Complete	TRUE	Deleted from CPT
G0204	Diagnostic mar	Mammography	January 2016	20			ACR	Assume CI	CMS Faste	February 2008							FALSE		TRUE	In the NPRM for 2015, CM	October 2(	38	Complete	TRUE	Deleted from CPT
G0206	Diagnostic mar	Mammography	January 2016	20			ACR	Assume CI	CMS Faste	February 2008							FALSE		TRUE	In the NPRM for 2015, CM	October 2(	38	Complete	TRUE	Deleted from CPT
G0237	Therapeutic pr	Respiratory Therapy	February 2009	38			ACCP/ATS	Remove fr	CMS Faste	February 2	XXX	0	0.27	NA	0.01	40969	FALSE		FALSE					TRUE	Remove from Screen
G0238	Therapeutic pr	Respiratory Therapy	February 2009	38			ACCP/ATS	Remove fr	CMS Faste	February 2	XXX	0	0.28	NA	0.01	49322	FALSE		FALSE					TRUE	Remove from Screen
G0248	Demonstratior	Home INR Monitorir	January 2017	19			ACC	Created Ca	High Volur	January 2(	XXX	0	1.87	NA	0.04	23312	FALSE		TRUE	In October 2015, AMA Sta	Septembe	08	yes	TRUE	Deleted from CPT
G0249	Provision of te	Home INR Monitorir	January 2017	19			ACC	Created Ca	CMS Faste	February 2	XXX	0	1.69	NA	0.01	1211835	FALSE		TRUE	In October 2015, AMA Sta	Septembe	08	yes	TRUE	Deleted from CPT
G0250	Physician revie	Home INR Monitorir	January 2017	19			ACC	Created Ca	CMS Faste	February 2	XXX	0.18	0.04	NA	0.01	185069	FALSE		TRUE	In October 2015, AMA Sta	Septembe	08	yes	TRUE	Deleted from CPT
G0268	Removal of im	Removal of Impacte	April 2017	35			AAO-HNS	0.61	CMS Faste	October 2(	000	0.61	0.79	0.27	0.09	166164	FALSE		FALSE					TRUE	Maintain
G0270	Medical nutriti	Medical Nutrition Th	January 2019	37			ADA	Maintain/I	CMS Faste	February 2	XXX	0.45	0.46	0.34	0.02	81177	FALSE		FALSE					TRUE	Maintain
G0279	Diagnostic digi	RAW	January 2018	31				Recomme	CMS-Othe	October 2(	ZZZ	0.6	0.95	NA	0.04	783467	FALSE		FALSE					TRUE	Remove from Screen
G0283	Electrical stim	Physical Medicine ar	January 2017	29			APTA	0.18	Low Value	October 2(	XXX	0.18	0.19	NA	0.01	7523149	FALSE		FALSE	In April 2016, the Relativity Assessment Workgroup reviewe				TRUE	Maintain
G0296	Counseling visi	RAW	October 2019	17	January 2(	RAW		Submit act	CMS-Othe	January 2(	XXX	0.52	0.27	0.20	0.04	50164	FALSE		FALSE					FALSE	
G0297	Low dose ct sc	Screening CT of Thor	October 2019	07				Recomme	CMS-Othe	October 2018						260400	FALSE		TRUE	In October 2018, AMA sta	May 2019	12	Complete	TRUE	Deleted from CPT
G0364	Bone marrow a	RAW	January 2018	31				Deleted fr	CMS-Othe	October 2017							FALSE		FALSE					TRUE	Deleted from CPT
G0365	Vessel mappin	Duplex Scan Arterial	January 2019	17			ACR, SIR, S	Deleted fr	CMS-Othe	October 2017						38289	FALSE		TRUE	In October 2017, the RAW	Septembe	36	complete	TRUE	Deleted from CPT
G0389	Ultrasound b-s	Abdominal Aorta Ult	October 2015	12			ACC, ACP,	CPT Assist	Final Rule	July 2014							TRUE	Jan 2017	yes	TRUE	When Medicare began pa	May 2015	23	Complete	TRUE	Deleted from CPT
G0396	Alcohol and/or substance (other th		January 2018	31			AAFP, ASA	Refer to CI	CMS-Othe	October 2(	XXX	0.65	0.34	0.25	0.05	51068	FALSE		TRUE	In October 2017, the RAW	Time Uncertain			FALSE	
G0399	Home sleep test (hst) with type iii p		January 2019	37				CMS delet	High Volur	October 2(	XXX	0	0.00	NA	0.00	112455	FALSE		FALSE					TRUE	Deleted from CPT
G0402	Initial preventi	Initial Preventive Ex	October 2016	35			No Special	RUC recon	CMS-Othe	April 2016	XXX	2.6	2.11	1.14	0.15	526509	FALSE		FALSE					TRUE	Maintain
G0403	Electrocardiog	EKG for Initial Preve	October 2016	35			No Special	RUC recon	CMS-Othe	April 2016	XXX	0.17	0.24	NA	0.02	129413	FALSE		FALSE					TRUE	Maintain
G0407	Follow-up inpatient consultation, in		April 2021	24	April 2023	RAW	AAN, ANA,	Review ac	CMS-Othe	October 2(	XXX	1.39	NA	0.57	0.10	54207	FALSE		FALSE					FALSE	
G0408	Follow-up inpatient consultation, co		April 2021	24	April 2023	RAW	AAN, ANA,	Review ac	CMS-Othe	October 2(	XXX	2	NA	0.82	0.14	28734	FALSE		FALSE					FALSE	
G0416	Surgical patho	Prostate Biopsy - Pa	October 2015	16		RUC	ASC, CAP	4.00	Final Rule	July 2014	XXX	3.6	6.46	NA	0.09	133021	FALSE		FALSE					TRUE	Increase
G0422	Intensive cardiac rehabilitation; wit		January 2021	29				Maintain	CMS-Othe	October 2(	XXX	1.7	1.43	1.43	0.20	29034	FALSE		FALSE					TRUE	Remove from screen
G0423	Intensive cardiac rehabilitation; wit		January 2021	29				Maintain	CMS-Othe	October 2(	XXX	1.7	1.43	1.43	0.20	45564	FALSE		FALSE					TRUE	Remove from screen
G0436	Smoking and tc	RAW	October 2016	35		RUC		Deleted fr	CMS-Othe	April 2016							FALSE		FALSE					TRUE	Deleted from CPT
G0438	Annual wellne	RAW	April 2016	47			No Interes	RUC recon	CMS-Othe	April 2013	XXX	2.6	2.10	NA	0.15	1114054	FALSE		FALSE	The Workgroup asked CMS why G codes are developed. CM				TRUE	Remove from screen
G0439	Annual wellne	RAW	April 2016	47			No Interes	RUC recon	CMS-Othe	April 2013	XXX	1.92	1.78	NA	0.13	8360475	FALSE		FALSE	The Workgroup asked CMS why G codes are developed. CM				TRUE	Remove from screen
G0442	Annual alcoho	Annual Alcohol Scre	October 2016	35			No Special	RUC recon	CMS-Othe	April 2016	XXX	0.18	0.35	0.08	0.01	893133	FALSE		FALSE					TRUE	Maintain
G0444	Annual depres	Annual Depression S	October 2016	35			No Special	RUC recon	CMS-Othe	April 2016	XXX	0.18	0.35	0.08	0.01	2127052	FALSE		FALSE					TRUE	Maintain
G0446	Annual, face-to	Intensive Behavioral	January 2018				No Special	Survey, bu	CMS-Othe	October 2(	XXX	0.45	0.28	0.20	0.04	253992	FALSE		FALSE					TRUE	Maintain
G0447	Face-to-face bi	Behavioral Counselir	October 2016	35			No Special	RUC recon	CMS-Othe	April 2016	XXX	0.45	0.28	0.20	0.04	336973	FALSE		FALSE					TRUE	Maintain
G0452	Molecular patl	Molecular Patholog	October 2019	13				0.93	CMS-Othe	October 2(	XXX	0.93	0.44	NA	0.05	128942	FALSE		FALSE					TRUE	Increase
G0453	Continuous int	RAW	October 2016	35				Remove fr	CMS-Othe	April 2016	XXX	0.6	NA	0.30	0.05	402739	FALSE		FALSE					TRUE	Remove from screen

G0456	Negative press	Negative Pressure W	January 2014	17				RUC recon	CMS Requ	November 2012							FALSE		TRUE	In January 2013, the RAW	May 2013	28	Complete	TRUE	Deleted from CPT
G0457	Negative press	Negative Pressure W	January 2014	17				RUC recon	CMS Requ	November 2012							FALSE		TRUE	In January 2013, the RAW	May 2013	28	complete	TRUE	Deleted from CPT
G0500	Moderate sedation services provid		January 2021	29				Maintain	CMS-Othe	October 2(	XXX	0.1	1.57	0.04	0.02	490072	FALSE		FALSE					TRUE	Remove from screen
G0506	Comprehensive assessment of and		October 2021	20				Request C	CMS-Othe	October 2(	ZZZ	0.87	0.85	0.37	0.05	119106	FALSE		FALSE					TRUE	Request CMS Delete
G6001	Ultrasonic guidance for placement		January 2021	29	April 2022	RUC	AADA, AST	Refer to CI	CMS-Othe	October 2(	XXX	0.58	3.88	NA	0.03	124968	FALSE		TRUE	The RUC identified G6001	February 2022			FALSE	
G6002	Stereoscopic x-ray guidance for loc		January 2018	31				Remove fr	CMS-Othe	October 2(	XXX	0.39	1.80	NA	0.02	1291326	FALSE		FALSE					TRUE	Remove from screen
G6012	Radiation treatment delivery,3 or n		January 2021	29	October 2(	RAW		Review ac	CMS-Othe	October 2(	XXX	0	7.57	NA	0.02	357383	FALSE		FALSE					FALSE	
G6013	Radiation treatment delivery,3 or n		January 2021	29	October 2(	RAW		Review ac	CMS-Othe	October 2(	XXX	0	7.59	NA	0.02	218027	FALSE		FALSE					FALSE	
G6014	Radiation treat	RAW	October 2019	17				Remove fr	CMS-Othe	January 2(	XXX	0	7.57	NA	0.02	22014	FALSE		FALSE					TRUE	Remove from Screen
G6015	Intensity modulated treatment deli		January 2021	29	October 2(	RAW		Review ac	CMS-Othe	October 2(	XXX	0	11.01	NA	0.04	1297349	FALSE		FALSE					FALSE	
G6017	Intra-fraction localization and track		January 2021	29	October 2(	RAW		Review ac	CMS-Othe	October 2(	YYY	0	0.00	0.00	0.00	86769	FALSE		FALSE					FALSE	
G2211	Visit complexit	Visit Complexity E/M	January 2020	34				No recom	CMS Requ	November 2019							FALSE		FALSE					TRUE	N/A
P3001	Screening pap	Cytopathology Cervi	April 2018	26			CAP	0.42	CMS-Othe	October 2(	XXX	0.26	0.36	0.36	0.01	1599	FALSE		FALSE					TRUE	Maintain
Q0091	Screening pap	RAW	January 2019	37			No Special	RUC recon	CMS-Othe	October 2(	XXX	0.37	0.85	0.14	0.04	533729	FALSE		FALSE					TRUE	Maintain

RUC Referrals to CPT Editoral Panel - Outstanding Issues

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37220	**Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37221	**Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37222	**Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (list separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37223	**Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37224	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37225	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37226	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37227	**Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37228	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37229	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1 / PE Screen - High Cost Supplies / High Volume Growth5	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37230	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37231	**Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37232	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty (list separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37233	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37234	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
37235	**Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed (list separately in addition to code for primary procedure)**	High Volume Growth1	January 2019	SVS, ACS, SIR, ACR, ACC	February 2022

Background: In October 2018, 37225, 37227 and 37229 services were identified by the PE High Cost Supplies screen for services with non-facility Medicare utilization over 10,000, not reviewed in the last five years and include a supply item greater than $500. The RUC requests an action plan for the January 2019 on how to address these services. The Workgroup reviewed the action plan for these services, noting that CMS repriced these supply items for 2019. The specialty societies indicated that they agreed these supply items were essential to perform CPT codes 37225, 37227 and 37229 and that the current repricing was appropriate. The Workgroup noted that CPT code 37229 was identified on the High Volume Growth screen at this meeting and the Workgroup agreed with the specialty societies to refer this entire family of services to CPT for revision to accommodate new technologies.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
76998	**Ultrasonic guidance, intraoperative**	CMS-Other - Utilization over 20,000 Part1	October 2019	STS, AATS, ACS, ASBrS, AUA, AVLS, SCAI, SIR, SVS	February 2022

Background: In October 2018, the Workgroup discussed future screens and recommends lowering the threshold and examining the list of CMS/Other source codes with Medicare utilization over 20,000. In October 2019, the RUC refers this issued to CPT Editorial Panel to more accurately differentiate physician work as multiple specialties currently use this code and to clarify correct coding.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
99415	**Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (list separately in addition to code for outpatient evaluation and management service)**	CMS Request - Final Rule for 2020	April 2021	AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS	February 2022

Background: In October 2020, the RUC recommends that CPT codes 99358 and 99459 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 and the 2023 Medicare Physician Payment Schedule (February 2021, CPT Tab 11). At the April 2021 review, there was discussion at both the PE Subcommittee meeting and the RUC regarding discrepancies between the long descriptors for these codes and the introductory CPT language. The descriptors for 99415 and 99416 state “direct patient contact with physician supervision;” while the preparatory paragraph for these codes describes “face-to-face time.” Given these inconsistencies, there was confusion as to whether the two codes could be used for non-face-to-face (asynchronous) patient encounters. The CPT representative stated that the CPT Editorial Panel is working to reconcile the language. Regardless, the PE Subcommittee agreed that the practice expense inputs for CPT codes 99415 and 99416 were appropriate and that the recommended clinical staff times are correctly valued.

RUC Referrals to CPT Editoral Panel - Outstanding Issues

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
99416	**Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (list separately in addition to code for prolonged service)**	CMS Request - Final Rule for 2020	April 2021	AAHPM, AAP, CHEST, ACP, AGS, ANA, ASCO, ATS, SVS	February 2022

Background: In October 2020, the RUC recommends that CPT codes 99358 and 99459 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the CPT 2023 and the 2023 Medicare Physician Payment Schedule (February 2021, CPT Tab 11). At the April 2021 review, there was discussion at both the PE Subcommittee meeting and the RUC regarding discrepancies between the long descriptors for these codes and the introductory CPT language. The descriptors for 99415 and 99416 state “direct patient contact with physician supervision;” while the preparatory paragraph for these codes describes “face-to-face time.” Given these inconsistencies, there was confusion as to whether the two codes could be used for non-face-to-face (asynchronous) patient encounters. The CPT representative stated that the CPT Editorial Panel is working to reconcile the language. Regardless, the PE Subcommittee agreed that the practice expense inputs for CPT codes 99415 and 99416 were appropriate and that the recommended clinical staff times are correctly valued.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
G0396	**Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes**	CMS-Other - Utilization over 30,000	January 2018	AAFP, ASA, ASAM	Time Uncertain

Background: In October 2017, the RAW requested that AMA staff compile a list of CMS/Other codes with Medicare utilization of 30,000 or more. This list resulted in 34 services and the RAW requested action plans to be reviewed at the January 2018 meeting. In January 2018, the RUC recommended to maintain the physician work and refer to CPT to editorially remove "screening” from 99408 and 99409 to “assessment” to mirror G0396. At the February 2018 CPT meeting, the Panel postponed until time uncertain this request to revise codes 99408-99409 to identify assessment of alcohol and/or substance abuse. As a rationale for postponement, the Panel said that the service described in this application did not meet the General Criteria for Category I because the proposed service is not unique or well defined, and does not describe a service that is clearly identified and distinguished from existing services already described in CPT by other codes. The Panel’s additional rationale for postponement of this item was to allow the relevant specialty societies an opportunity to submit a new code change application to address the differences between assessment and screening services.

		Screen	RUC Meeting	Specialty Society:	CPT Meeting
G6001	**Ultrasonic guidance for placement of radiation therapy fields**	CMS-Other - Utilization over 20,000 Part2	January 2021	AADA, ASTRO	February 2022

Background: The RUC identified G6001 via the CMS/Other Source Utilization over 20,000 screen. In January 2021, the RUC recommended to refer to CPT to develop new code(s) that reflect the different process of care between the two specialties (dermatology and radiation oncology).

RUC Recommendations to Develop CPT Assistant Articles - Outstanding Issues

		Screen:	RUC Meeting:	RUC Rec:	Specialty Society:	CPT Asst Status:
63685	**Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling**	Site of Service Anomaly / CMS Fastest Growing/ High Volume Growth7	January 2021	Review action plan in 2 years after CPT article published. 6.05	AAPM, AANS/CNS, ASA, ISIS, NASS	

Background: Oct 2010 re-reviewed site of service issue. In October 2020, the RUC identified six codes with Medicare utilization of 10,000 or more that have increased by at least 100% from 2014 through 2019e. CPT codes 00918, 63685, 75561, 75572, 75574 and 93655. The Workgroup requested that the specialty societies submit an action plan for codes CPT codes 00918, 63685, 75561, 75572, 75574 and 93655 for January 2021. In January 2021, the RUC recommended to refer to CPT Assistant. A CPT Assistant article has already been submitted. The RUC will reeview after 2 years of data are available after article is published.

Physician Time from RUC Meeting:
October 2021 (CPT 2023)

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time
64400	7	1	1	6	5													20
64405	5	1	0	5	5													16
64408	7	3	0	5	5													20
64415	13	1	4	10	7													35
64416	13	1	5	15	10													44
64417	13	1	4	10	10													38
64418	6	3	3	10	10													32
64420	13	1	5	10	5													34
64421	0	0	0	10	0													10
64425	7	1	1	11	5													25
64430	13	5	5	10	10													43
64435	7	3	0	5	5													20
64445	7	1	1	10	5													24
64446	13	1	5	15	10													44
64447	12	1	3	8	5													29
64448	13	1	5	15	9													43
64449	13	1	5	14	5													38
64450	7	1	1	5	5													19
64451	17	1	5	15	7													45
64454	17	1	5	18	10													51
64455	5	1	5	5	5													21
73580	5	0	0	14	5													24
76377	5	0	0	15	5													25
76942	7	0	0	15	5													27
77002	0	2	0	15	0													17
77003	0	2	0	15	0													17
93563	0	0	0	15	0													15
93564	0	0	0	18	0													18
93565	0	0	0	10	0													10
93566	0	0	0	10	0													10
93567	0	0	0	10	0													10
93568	0	0	0	13	0													13
99242	5	0	0	20	5													30
99243	7	0	0	30	7													44
99244	10	0	0	40	10													60
99245	15	0	0	55	17													87
99315	10	0	0	25	5													40
99316	15	0	0	40	8													63
99341	6	0	0	15	6													27
99342	10	0	0	32	10													52
99344	15	0	0	60	17													92
99345	25	0	0	74	27													126
99347	5	0	0	20	5													30
99348	7	0	0	29	10													46

Physician Time from RUC Meeting:
October 2021 (CPT 2023)

CPT Code	Pre-Service Evaluation	Pre-Service Positioning	Pre-Service Scrub Dress & Wait	Intra-Service	Immediate Post Service	99211	99212	99213	99214	99215	99231	99232	99233	99238	99239	99291	99292	Total Time
99349	12	0	0	41	15													68
99350	17	0	0	60	20													97
99358	0	0	0	50	0													50
99359	0	0	0	30	0													30
0004A	0	0	0	7	0													7
0051A	0	0	0	7	0													7
0052A	0	0	0	7	0													7
0053A	0	0	0	7	0													7
0054A	0	0	0	7	0													7
0064A	0	0	0	7	0													7
0071A	0	0	0	7	0													7
0072A	0	0	0	7	0													7
33900	50	6	15	90	45													206
33901	50	6	15	120	45													236
33902	50	6	15	90	48													209
33903	50	6	15	120	50													241
33904	0	0	0	45	0													45
93569	0	0	0	11	0													11
93573	0	0	0	18	0													18
93574	0	0	0	20	0													20
93575	0	0	0	20	0													20
95919	1	0	0	5	1													7

Detailed Description of Pre-Service Time Packages (Minutes)

		FACILITY				NON-FAC	
		1	2	3	4	5**	6
	Total Pre-Service Time	**20**	**25**	**51**	**63**	**8**	**23**
	CATEGORY SUBTOTALS						
A	Pre-Service Evaluation (IWPUT =0.0224)	13	18	33	40	7	17
B	Pre-Service Positioning (IWPUT = 0.0224)	1	1	3	3	0	1
C	Pre-Service Scrub, Dress and Wait (IWPUT =0.0081)	6	6	15	20	1	5
	DETAILS						
A	History and Exam (Performance and review of appropriate Pre-Tests)	5	10	10	15	4	9
A	Prepare for Procedure (Check labs, plan, assess risks, review procedure)	2	2	2	4	1	1
A	Communicate with patient and/or family (Discuss procedure/ obtain consent)	3	3	5	5	2	3
A	Communicate with other professionals	0	0	5	5	0	2
A	Check/set-up room, supplies and equipment	1	1	5	5	0	1
A	Check/ prepare patient readiness (Gown, drape, prep, mark)	1	1	5	5	0	1
A	Prepare/ review/ confirm procedure	1	1	1	1	0	0
B	Perform/ supervise patient positioning	1	1	3	3	0	1
C	Administer local/topical anesthesia	1	1	0	0	1	5
C	Observe (wait anesthesia care)	0	0	10	15	0	0
C	Dress and scrub for procedure	5	5	5	5	0	0

**If the procedure does not require local anesthesia, 1 minute should be removed from pre-service time

1 Straightforward Patient/Straightforward Procedure (No anesthesia care)
2 Difficult Patient/Straightforward Procedure (No anesthesia care)
3 Straightforward Patient/Difficult Procedure
4 Difficult Patient/Difficult Procedure
5 Procedure with minimal anesthesia care (If no anesthesia care deduct 1 minute)
6 Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect

Additional Positioning Times for Spinal Surgical Procedures

SS1	Anterior Neck Surgery (Supine) (eg ACDF)	15 Minutes
SS2	Posterior Neck Surgery (Prone) (eg laminectomy)	25 Minutes
SS3	Posterior Thoracic/Lumbar (Prone) (eg laminectomy)	15 Minutes
SS4	Lateral Thoracic/Lumbar (Lateral) (eg corpectomy)	25 Minutes
SS5	Anterior Lumbar (Supine) (eg ALIF)	15 Minutes

Additional Positioning Times for Spinal Injection Procedures

SI1	Anterior Neck Injection (Supine) (eg discogram)	7 Minutes
SI2	Posterior Neck Injection (Prone) (eg facet)	5 Minutes
SI3	Posterior Thoracic/Lumbar (Prone) (eg epidural)	5 Minutes
SI4	Lateral Thoracic/Lumbar (Lateral) (eg discogram)	7 Minutes

Additional Positioning Times for Urological Procedures

U1	Dorsal Lithotomy	5 Minutes

Notes:

- Roll-over cells for additional detail where available
- Straightforward procedure: Integumentary, Non-incisional endoscopy, natural orifice

Detailed Description of Facility Based Post-Service Time Packages (Minutes)						
	7A Local Anesthesia/ Straightforward Procedure	**7B Local Anesthesia/ Complex Procedure**	**8A IV Sedation/ Straightforward Procedure**	**8B IV Sedation/ Complex Procedure**	**9A General Anesthesia or Complex Regional Block/ Straightforward Procedure**	**9B General Anesthesia or Complex Regional Block/Complex Procedure**
Total Post-Service Time	**18**	**21**	**25**	**28**	**30**	**33**
Details:						
Application of Dressing[1]	2	2	2	2	2	2
Transfer of supine patient off table	1	1	1	1	1	1
Operative Note	5	5	5	5	5	5
Monitor patient recovery/stabilization	1	1	5	5	10	10
Communication with patient and/or family	5	5	5	5	5	5
Written post-operative note	2	5	2	5	2	5
Post-Operative Orders and Order Entry	2	2	5	5	5	5

Advisors may request additional time for circumstances that require additional work beyond the type of work described

1 This represents a simple dressing

CPT	RUC Recommended PLI Crosswalk
64400	64400
64405	64405
64408	64408
64415	64415
64416	64416
64417	64417
64418	64418
64420	64420
64421	64421
64425	64425
64430	64430
64435	64435
64445	64445
64446	64446
64447	64447
64448	64448
64449	64449
64450	64450
64451	64451
64454	64454
64455	64455
73580	73722
76377	76377
76942	76942
77002	77002
77003	77003
93563	93563
93564	93564
93565	93565
93566	93566
93567	93567
93568	93568
99242	99242
99243	99243
99244	99244
99245	99245
99315	99315
99316	99316
99341	99341
99342	99342
99344	99344

99345	99345
99347	99342
99348	99348
99349	99349
99350	99350
99358	99358
99359	99359
0004A	90460
0051A	90460
0052A	90460
0053A	90460
0054A	90460
0064A	90460
0071A	90460
0072A	90460
33900	93530
33901	93530
33902	93530
33903	93530
33904	93530
93569	93568
93573	93568
93574	93568
93575	93568
95919	92136

CPT	BETOS Class	BETOS Subclass	BETOS Subclass2
64400	Procedures	Minor procedure	Other
64405	Procedures	Minor procedure	Other
64408	Procedures	Minor procedure	Other
64415	Procedures	Minor procedure	Other
64416	Procedures	Minor procedure	Other
64417	Procedures	Minor procedure	Other
64418	Procedures	Minor procedure	Other
64420	Procedures	Minor procedure	Other
64421	Procedures	Minor procedure	Other
64425	Procedures	Minor procedure	Other
64430	Procedures	Minor procedure	Other
64435	Procedures	Minor procedure	Other
64445	Procedures	Minor procedure	Other
64446	Procedures	Minor procedure	Other
64447	Procedures	Minor procedure	Other
64448	Procedures	Minor procedure	Other
64449	Procedures	Minor procedure	Other
64450	Procedures	Minor procedure	Other
64451	Procedures	Minor procedure	Other
64454	Procedures	Minor procedure	Other
64455	Procedures	Minor procedure	Other
73580	Imaging	Imaging/procedure	Other
76377	Imaging	Imaging/procedure	Other
76942	Imaging	Echography/ultrasonography	Other
77002	Imaging	Imaging/procedure	Other
77003	Imaging	Imaging/procedure	Other
93563	Procedures	Major procedure	Cardiovascular-Other
93564	Procedures	Major procedure	Cardiovascular-Other
93565	Procedures	Major procedure	Cardiovascular-Other
93566	Procedures	Major procedure	Cardiovascular-Other
93567	Procedures	Major procedure	Cardiovascular-Other
93568	Procedures	Major procedure	Cardiovascular-Other
99242	Evaluation Management	Office visit	New
99243	Evaluation Management	Office visit	New
99244	Evaluation Management	Office visit	New
99245	Evaluation Management	Office visit	New
99315	Evaluation Management	Nursing home visit	NA
99316	Evaluation Management	Nursing home visit	NA
99341	Evaluation Management	Home visit	NA
99342	Evaluation Management	Home visit	NA
99344	Evaluation Management	Home visit	NA
99345	Evaluation Management	Home visit	NA
99347	Evaluation Management	Home visit	NA
99348	Evaluation Management	Home visit	NA
99349	Evaluation Management	Home visit	NA
99350	Evaluation Management	Home visit	NA
99358	Evaluation Management	NA	NA

99359	Evaluation Management	NA	NA
0004A	Other	Immunizations/Vaccinations	NA
0051A	Other	Immunizations/Vaccinations	NA
0052A	Other	Immunizations/Vaccinations	NA
0053A	Other	Immunizations/Vaccinations	NA
0054A	Other	Immunizations/Vaccinations	NA
0064A	Other	Immunizations/Vaccinations	NA
0071A	Other	Immunizations/Vaccinations	NA
0072A	Other	Immunizations/Vaccinations	NA
33900	Procedures	Major procedure	Cardiovascular-Other
33901	Procedures	Major procedure	Cardiovascular-Other
33902	Procedures	Major procedure	Cardiovascular-Other
33903	Procedures	Major procedure	Cardiovascular-Other
33904	Procedures	Major procedure	Cardiovascular-Other
93569	Procedures	Major procedure	Cardiovascular-Other
93573	Procedures	Major procedure	Cardiovascular-Other
93574	Procedures	Major procedure	Cardiovascular-Other
93575	Procedures	Major procedure	Cardiovascular-Other
95919	Tests	Other tests	Other

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
93799		1,200	33900	40	0.033	0.00	14.00	04 Endovascular Pulmonary Arterial Revasc	560	0
93799		1,200	33901	40	0.033	0.00	18.00	04 Endovascular Pulmonary Arterial Revasc	720	0
93799		1,200	33902	40	0.033	0.00	17.33	04 Endovascular Pulmonary Arterial Revasc	693	0
93799		1,200	33903	40	0.033	0.00	20.00	04 Endovascular Pulmonary Arterial Revasc	800	0
93799		1,200	33904	40	0.033	0.00	7.27	04 Endovascular Pulmonary Arterial Revasc	291	0
93799		1,200	93799	1,000	0.833	0.00	0.00	04 Endovascular Pulmonary Arterial Revasc	0	0
64415		199,150	64415	199,150	1.000	1.35	1.50	05 Somatic Nerve Injections	298,725	268,853
76942		1,178,266	Savings	172,862	0.147	0.67	0.00	05 Somatic Nerve Injections	0	115,818
64416		17,912	64416	17,912	1.000	1.48	1.80	05 Somatic Nerve Injections	32,242	26,510
76942		1,178,266	Savings	15,780	0.013	0.67	0.00	05 Somatic Nerve Injections	0	10,573
64417		15,765	64417	15,765	1.000	1.27	1.31	05 Somatic Nerve Injections	20,652	20,022
76942		1,178,266	Savings	12,376	0.011	0.67	0.00	05 Somatic Nerve Injections	0	8,292
64445		130,719	64445	130,719	1.000	1.00	1.39	05 Somatic Nerve Injections	181,699	130,719
76942		1,178,266	Savings	89,935	0.076	0.67	0.00	05 Somatic Nerve Injections	0	60,256
64446		5,880	64446	5,880	1.000	1.36	1.75	05 Somatic Nerve Injections	10,290	7,997
76942		1,178,266	Savings	4,898	0.004	0.67	0.00	05 Somatic Nerve Injections	0	3,282
64447		282,703	64447	282,703	1.000	1.10	1.34	05 Somatic Nerve Injections	378,822	310,973
76942		1,178,266	Savings	246,800	0.209	0.67	0.00	05 Somatic Nerve Injections	0	165,356
64448		40,188	64448	40,188	1.000	1.41	1.68	05 Somatic Nerve Injections	67,516	56,665
76942		1,178,266	Savings	34,964	0.030	0.67	0.00	05 Somatic Nerve Injections	0	23,426
77002		528,759	77002	528,759	1.000	0.54	0.54	05 Somatic Nerve Injections	285,530	285,530
77003		77,998	77003	77,998	1.000	0.60	0.60	05 Somatic Nerve Injections	46,799	46,799
76942		1,178,266	76942	600,651	0.510	0.67	0.67	05 Somatic Nerve Injections	402,436	402,436
64400		36,483	64400	36,483	1.000	0.75	1.00	05 Somatic Nerve Injections	36,483	27,362
64405		134,871	64405	134,871	1.000	0.94	0.94	05 Somatic Nerve Injections	126,779	126,779
64408		538	64408	538	1.000	0.75	0.90	05 Somatic Nerve Injections	484	404
64418		31,818	64418	31,818	1.000	1.10	1.10	05 Somatic Nerve Injections	35,000	35,000
64420		3,812	64420	3,812	1.000	1.08	1.18	05 Somatic Nerve Injections	4,498	4,117
64421		18,541	64421	18,541	1.000	0.50	0.60	05 Somatic Nerve Injections	11,125	9,271
64425		7,963	64425	7,963	1.000	1.00	1.19	05 Somatic Nerve Injections	9,476	7,963
64430		4,007	64430	4,007	1.000	1.00	1.15	05 Somatic Nerve Injections	4,608	4,007
64435		38	64435	38	1.000	0.75	0.75	05 Somatic Nerve Injections	29	29
64449		1,957	64449	1,957	1.000	1.27	1.55	05 Somatic Nerve Injections	3,033	2,485
64450		467,316	64450	467,316	1.000	0.75	0.75	05 Somatic Nerve Injections	350,487	350,487
64451		-	64451	-	1.000	1.52	1.52	05 Somatic Nerve Injections	0	0
64454		-	64454	-	1.000	1.52	1.52	05 Somatic Nerve Injections	0	0
64455		74,450	64455	74,450	1.000	0.75	0.75	05 Somatic Nerve Injections	55,838	55,838
93563		167	93563	167	1.000	1.11	1.11	08 Pulmonary Angiography	185	185
93564		6	93564	6	1.000	1.13	1.13	08 Pulmonary Angiography	7	7
93565		80	93565	80	1.000	0.86	0.86	08 Pulmonary Angiography	69	69
93566		388	93566	388	1.000	0.86	0.86	08 Pulmonary Angiography	334	334
93567		28,640	93567	28,640	1.000	0.97	0.97	08 Pulmonary Angiography	27,781	27,781
93568		1,334	93568	400	0.300	0.88	0.88	08 Pulmonary Angiography	352	352
93568		1,334	93569	334	0.250	0.88	1.05	08 Pulmonary Angiography	351	294
93568		1,334	93573	334	0.250	0.88	1.75	08 Pulmonary Angiography	585	294
93568		1,334	93574	133	0.100	0.88	1.84	08 Pulmonary Angiography	245	117
93568		1,334	93575	133	0.100	0.88	1.91	08 Pulmonary Angiography	254	117

CPT Source	Deleted	Source 2019 Utilization	New/ Revised Code	New/Revised Code Utilization (reference 2019)	Percent	Source RVU	RUC Rec RVU	RUC Tab	New/ Revised Total RVUs	Total Source RVUs
92499 (previously reported as 0341T)		7,015	95919	5,000	0.713	0.00	0.25	09 Quantitative Pupillometry Services	1,250	0
92499		7,015	92499	2,015	0.287	0.00	0.00	09 Quantitative Pupillometry Services	0	0
99241	D	0	99242	0	1.000	0.64	1.08	11 Consultations	0	0
99242		0	99242	0	1.000	1.34	1.08	11 Consultations	0	0
99243		0	99243	0	1.000	1.88	1.80	11 Consultations	0	0
99244		0	99244	0	1.000	3.02	2.69	11 Consultations	0	0
99245		0	99245	0	1.000	3.77	3.75	11 Consultations	0	0
99315		251,226	99315	251,226	1.000	1.28	1.50	12 Nursing Facility Discharge Day Services	376,839	321,569
99316		447,543	99316	447,543	1.000	1.90	2.50	12 Nursing Facility Discharge Day Services	1,118,858	850,332
99324	D	51,495	99341	51,495	1.000	1.01	1.00	13 Home and Residence Services	51,495	52,010
99341		13,532	99341	13,532	1.000	1.01	1.00	13 Home and Residence Services	13,532	13,667
99325	D	53,120	99342	53,120	1.000	1.52	1.65	13 Home and Residence Services	87,648	80,742
99342		40,526	99342	40,526	1.000	1.52	1.65	13 Home and Residence Services	66,868	61,600
99326	D	57,317	99344	57,317	1.000	2.63	2.87	13 Home and Residence Services	164,500	150,744
99343	D	56,201	99344	56,201	1.000	2.53	2.87	13 Home and Residence Services	161,297	142,189
99344		76,381	99344	76,381	1.000	3.38	2.87	13 Home and Residence Services	219,213	258,168
99327	D	67,147	99344	67,147	1.000	3.46	2.87	13 Home and Residence Services	192,712	232,329
99328	D	42,033	99345	42,033	1.000	4.09	3.88	13 Home and Residence Services	163,088	171,915
99345		71,563	99345	71,563	1.000	4.09	3.88	13 Home and Residence Services	277,664	292,693
99334	D	500,533	99347	500,533	1.000	1.07	0.90	13 Home and Residence Services	450,480	535,570
99347		177,575	99347	177,575	1.000	1.00	0.90	13 Home and Residence Services	159,818	177,575
99335	D	1,241,609	99348	1,241,609	1.000	1.72	1.50	13 Home and Residence Services	1,862,414	2,135,567
99348		496,369	99348	496,369	1.000	1.56	1.50	13 Home and Residence Services	744,554	774,336
99336	D	1,676,057	99349	1,676,057	1.000	2.46	2.44	13 Home and Residence Services	4,089,579	4,123,100
99349		1,153,095	99349	1,153,095	1.000	2.33	2.44	13 Home and Residence Services	2,813,552	2,686,711
99337	D	547,337	99350	547,337	1.000	3.58	3.60	13 Home and Residence Services	1,970,413	1,959,466
99350		490,520	99350	490,520	1.000	3.28	3.60	13 Home and Residence Services	1,765,872	1,608,906
99339	D	-	Savings	-	1.000	1.25	0.00	13 Home and Residence Services	0	0
99340	D	-	Savings	-	1.000	1.80	0.00	13 Home and Residence Services	0	0
99358		211,314	99358	211,314	1.000	2.10	1.80	14 Prolonged Service – Without Direct Patient Contact	380,365	443,759
99359		7,861	99359	7,861	1.000	1.00	0.75	14 Prolonged Service – Without Direct Patient Contact	5,896	7,861
73580		30,453	73580	30,453	1.000	0.54	0.59	16 Contrast X-Ray of Knee Joint	17,967	16,445
76377		190,343	76377	190,343	1.000	0.79	0.79	17 3D Rendering with Interpretation and Report	150,371	150,371
									19,702,018	19,844,418

Total Source RVUs	19,844,418
Total New/Revised RVUs	19,702,018
RVU Difference	142,400
CF	34.8931
CF Redistribution	**4,968,772**

New Technology/New Services List

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 30 mcg/0.3 ml dosage, diluent reconstituted; first dose	Dec 2020	Pfizer-SARS-CoV-2-IA		CPT 2020	January 2025		☐
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 30 mcg/0.3 ml dosage, diluent reconstituted; second dose	Dec 2020	Pfizer-SARS-CoV-2-IA		CPT 2020	January 2025		☐
0003A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; third dose	Aug 2021	Pfizer-SARS-CoV-2-IA		CPT 2021	January 2025		☐
0004A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; booster dose	Oct 2021	Pfizer-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0011A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 100 mcg/0.5 ml dosage; first dose	Dec 2020	Moderna-SARS-CoV-2-IA		CPT 2020	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
0012A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, mrna-lnp, spike protein, preservative free, 100 mcg/0.5 ml dosage; second dose	Dec 2020	Moderna-SARS-CoV-2-IA		CPT 2020	January 2025		☐
0013A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; third dose	Aug 2021	Moderna-SARS-CoV-2-IA		CPT 2021	January 2025		☐
0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, dna, spike protein, chimpanzee adenovirus oxford 1 (chadox1) vector, preservative free, 5x1010 viral particles/0.5 ml dosage; first dose	Jan 2021	AstraZeneca-SARS-CoV-2-IA	34	CPT 2021	January 2025		☐
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, dna, spike protein, chimpanzee adenovirus oxford 1 (chadox1) vector, preservative free, 5x1010 viral particles/0.5 ml dosage; second dose	Jan 2021	AstraZeneca-SARS-CoV-2-IA	34	CPT 2021	January 2025		☐
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, dna, spike protein, adenovirus type 26 (ad26) vector, preservative free, 5x1010 viral particles/0.5 ml dosage, single dose	Jan 2021	Janssen-SARS-CoV-2-IA	34	CPT 2021	January 2025		☐
0041A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 ml dosage; first dose	Apr 2021	Novavax-SARS-CoV-2-IA	27	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
0042A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sars-cov-2) (coronavirus disease [covid-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 ml dosage; second dose	Apr 2021	Novavax-SARS-CoV-2-IA	27	CPT 2021	January 2025		☐
0051A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; first dose	Oct 2021	Pfizer Tris-Sucrose-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0052A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; second dose	Oct 2021	Pfizer Tris-Sucrose-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0053A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; third dose	Oct 2021	Pfizer Tris-Sucrose-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0054A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; booster dose	Oct 2021	Pfizer Tris-Sucrose-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0064A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, booster dose	Oct 2021	Moderna Booster-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
0071A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose	Oct 2021	Pfizer Tris-Sucrose-Age5-11-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
0072A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; second dose	Oct 2021	Pfizer Tris-Sucrose-Age5-11-SARS-CoV-2-IA	24	CPT 2021	January 2025		☐
10011	Fine needle aspiration biopsy, including mr guidance; first lesion	Jan 2018	Fine Needle Aspiration	04	CPT 2019	January 2023		☐
10012	Fine needle aspiration biopsy, including mr guidance; each additional lesion (list separately in addition to code for primary procedure)	Jan 2018	Fine Needle Aspiration	04	CPT 2019	January 2023		☐
14302	Adjacent tissue transfer or rearrangement, any area; each additional 30.0 sq cm, or part thereof (list separately in addition to code for primary procedure)	Apr 2009	Adjacent Tissue Transfer	4	CPT 2010	October 2015	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15272	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15273	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15274	Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15275	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15276	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area up to 100 sq cm; each additional 25 sq cm wound surface area, or part thereof (list separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15277	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; first 100 sq cm wound surface area, or 1% of body area of infants and children	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
15278	Application of skin substitute graft to face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (list separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
15769	Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; each additional 50 cc injectate, or part thereof (list separately in addition to code for primary procedure)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐
15773	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐
15774	Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; each additional 25 cc injectate, or part thereof (list separately in addition to code for primary procedure)	Oct 2018	Tissue Grafting Procedures	04	CPT 2020	January 2024		☐
15777	Implantation of biologic implant (eg, acellular dermal matrix) for soft tissue reinforcement (ie, breast, trunk) (list separately in addition to code for primary procedure)	Apr 2011	Chronic Wound Dermal Substitute	4	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17106	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
17107	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); 10.0 to 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
17108	Destruction of cutaneous vascular proliferative lesions (eg, laser technique); over 50.0 sq cm	Oct 2008	Destruction of Skin Lesions	11	CPT 2009	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	Apr 2006	Fibroadenoma Cryoablation	11	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
19294	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (iort) concurrent with partial mastectomy (list separately in addition to code for primary procedure)	Oct 2016	Intraoperative Radiation Therapy Applicator Procedures	07	CPT 2018	April 2022		☐
20560	Needle insertion(s) without injection(s); 1 or 2 muscle(s)	Jan 2019	Trigger Point Dry Needling	41	CPT 2020	January 2024		☐
20561	Needle insertion(s) without injection(s); 3 or more muscles	Jan 2019	Trigger Point Dry Needling	41	CPT 2020	January 2024		☐
20696	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; initial and subsequent alignment(s), assessment(s), and computation(s) of adjustment schedule(s)	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
20697	Application of multiplane (pins or wires in more than 1 plane), unilateral, external fixation with stereotactic computer-assisted adjustment (eg, spatial frame), including imaging; exchange (ie, removal and replacement) of strut, each	Apr 2008	Computer Dependent External Fixation	6	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
20700	Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (list separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20701	Removal of drug-delivery device(s), deep (eg, subfascial) (list separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
20702	Manual preparation and insertion of drug-delivery device(s), intramedullary (list separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20703	Removal of drug-delivery device(s), intramedullary (list separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20704	Manual preparation and insertion of drug-delivery device(s), intra-articular (list separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20705	Removal of drug-delivery device(s), intra-articular (list separately in addition to code for primary procedure)	Oct 2018	Drug Delivery Implant Procedures	05	CPT 2020	January 2024		☐
20983	Ablation therapy for reduction or eradication of 1 or more bone tumors (eg, metastasis) including adjacent soft tissue when involved by tumor extension, percutaneous, including imaging guidance when performed; cryoablation	Apr 2014	Cryoablation Treatment of the Bone Tumors	04	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (list separately in addition to code for primary procedure)	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Resurvey for January 2012	☑
20986	Code Deleted CPT 2009	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	☑
20987	Code Deleted CPT 2009	Apr 2007	Computer Navigation	7	CPT 2008	September 2011	Code Deleted CPT 2009	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21011	Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21012	Excision, tumor, soft tissue of face or scalp, subcutaneous; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21013	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21014	Excision, tumor, soft tissue of face and scalp, subfascial (eg, subgaleal, intramuscular); 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21015	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; less than 2 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21016	Radical resection of tumor (eg, sarcoma), soft tissue of face or scalp; 2 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21552	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21554	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21555	Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21556	Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21557	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21558	Radical resection of tumor (eg, sarcoma), soft tissue of neck or anterior thorax; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21811	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 1-3 ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
21812	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 4-6 ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
21813	Open treatment of rib fracture(s) with internal fixation, includes thoracoscopic visualization when performed, unilateral; 7 or more ribs	Apr 2014	Internal Fixation of Rib Fracture	05	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
21930	Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21931	Excision, tumor, soft tissue of back or flank, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21932	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21933	Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
21935	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
21936	Radical resection of tumor (eg, sarcoma), soft tissue of back or flank; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22526	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22527	Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; 1 or more additional levels (list separately in addition to code for primary procedure)	Apr 2006	Percutaneous Intradiscal Annuloplast	13	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22856	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); single interspace, cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), single interspace, lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22858	Total disc arthroplasty (artificial disc), anterior approach, including discectomy with end plate preparation (includes osteophytectomy for nerve root or spinal cord decompression and microdissection); second level, cervical (list separately in addition to code for primary procedure)	Apr 2014	Total Disc Arthroplasty Additional Cervical Level Add-On Code	07	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
22861	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22862	Revision including replacement of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22864	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; cervical	Apr 2008	Cervical Arthroplasty	7	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
22865	Removal of total disc arthroplasty (artificial disc), anterior approach, single interspace; lumbar	Feb 2006	Lumbar Arthroplasty	8	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
22867	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
22868	Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; second level (list separately in addition to code for primary procedure)	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	October 2020	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	January 2021	Survey April 2021	☑
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level (list separately in addition to code for primary procedure)	Jan 2016	Insertion of Spinal Stability Distractive Device	05	CPT 2017	January 2021	Survey April 2021	☑
22900	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22901	Excision, tumor, soft tissue of abdominal wall, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22902	Excision, tumor, soft tissue of abdominal wall, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22903	Excision, tumor, soft tissue of abdominal wall, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
22904	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
22905	Radical resection of tumor (eg, sarcoma), soft tissue of abdominal wall; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23071	Excision, tumor, soft tissue of shoulder area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23073	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23075	Excision, tumor, soft tissue of shoulder area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23076	Excision, tumor, soft tissue of shoulder area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23077	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
23078	Radical resection of tumor (eg, sarcoma), soft tissue of shoulder area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23200	Radical resection of tumor; clavicle	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23210	Radical resection of tumor; scapula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
23220	Radical resection of tumor, proximal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
24073	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24075	Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24076	Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
24077	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24079	Radical resection of tumor (eg, sarcoma), soft tissue of upper arm or elbow area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24150	Radical resection of tumor, shaft or distal humerus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
24152	Radical resection of tumor, radial head or neck	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
25071	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25073	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25075	Excision, tumor, soft tissue of forearm and/or wrist area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
25076	Excision, tumor, soft tissue of forearm and/or wrist area, subfascial (eg, intramuscular); less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25077	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
25078	Radical resection of tumor (eg, sarcoma), soft tissue of forearm and/or wrist area; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
25170	Radical resection of tumor, radius or ulna	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26111	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26113	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26115	Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26116	Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26117	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
26118	Radical resection of tumor (eg, sarcoma), soft tissue of hand or finger; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26250	Radical resection of tumor, metacarpal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26260	Radical resection of tumor, proximal or middle phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
26262	Radical resection of tumor, distal phalanx of finger	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27043	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27045	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27047	Excision, tumor, soft tissue of pelvis and hip area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27048	Excision, tumor, soft tissue of pelvis and hip area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27049	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27059	Radical resection of tumor (eg, sarcoma), soft tissue of pelvis and hip area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27075	Radical resection of tumor; wing of ilium, 1 pubic or ischial ramus or symphysis pubis	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27076	Radical resection of tumor; ilium, including acetabulum, both pubic rami, or ischium and acetabulum	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27077	Radical resection of tumor; innominate bone, total	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27078	Radical resection of tumor; ischial tuberosity and greater trochanter of femur	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	Apr 2014	Sacroiliac Joint Fusion	08	CPT 2015	October 2018	Surveyed in April 2018 for a CMS Request in the Final Rule for 2018	☑
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed	Sep 2014	Sacroiliac Joint Fusion	06	CPT 2016	October 2019	Remove form list, was only identified with 27279 and that code has been resurveyed April 2018.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27327	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27328	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27329	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27337	Excision, tumor, soft tissue of thigh or knee area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27339	Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27364	Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27365	Radical resection of tumor, femur or knee	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27615	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27616	Radical resection of tumor (eg, sarcoma), soft tissue of leg or ankle area; 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27618	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27619	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); less than 5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27632	Excision, tumor, soft tissue of leg or ankle area, subcutaneous; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
27634	Excision, tumor, soft tissue of leg or ankle area, subfascial (eg, intramuscular); 5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27645	Radical resection of tumor; tibia	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27646	Radical resection of tumor; fibula	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
27647	Radical resection of tumor; talus or calcaneus	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28039	Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28041	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28043	Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28045	Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28046	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; less than 3 cm	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28047	Radical resection of tumor (eg, sarcoma), soft tissue of foot or toe; 3 cm or greater	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2017	Review the data for the melanoma diagnoses within these services and the site of service in 2 years (October 2017). In October 2017, recommended to remove from the list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
28171	Radical resection of tumor; tarsal (except talus or calcaneus)	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28173	Radical resection of tumor; metatarsal	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
28175	Radical resection of tumor; phalanx of toe	Feb 2009	Excision of Soft Tissue and Bone Tumors		CPT 2010	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
29582	Code Deleted CPT 2018	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2018	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). Code Deleted for CPT 2018.	☑
29583	Code Deleted CPT 2018	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	October 2018	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). Code Deleted for CPT 2018.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
29584	Application of multi-layer compression system; upper arm, forearm, hand, and fingers	Oct 2010	Multi-Layer Compression System-HCPAC	74	CPT 2012	April 2022	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018). In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
29828	Arthroscopy, shoulder, surgical; biceps tenodesis	Apr 2007	Arthroscopic Biceps Tenodesis	17	CPT 2008	September 2011	Resurvey for January 2012	☑
29914	Arthroscopy, hip, surgical; with femoroplasty (ie, treatment of cam lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
29915	Arthroscopy, hip, surgical; with acetabuloplasty (ie, treatment of pincer lesion)	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
29916	Arthroscopy, hip, surgical; with labral repair	Apr 2010	Hip Arthroscopy	5	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
31295	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); maxillary sinus ostium, transnasal or via canine fossa	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31296	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); frontal sinus ostium	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
31297	Nasal/sinus endoscopy, surgical, with dilation (eg, balloon dilation); sphenoid sinus ostium	Feb 2010	Nasal Sinus Endoscopy with Ballooon Dilation	6	CPT 2011	October 2016	Surveying for January 2017 as part of bundling	☑
31626	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31627	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with computer-assisted, image-guided navigation (list separately in addition to code for primary procedure[s])	Feb 2009	Navigational Bronchoscopy	9	CPT 2010	October 2016	Review practice expense January 2014. Review data again in 3 years (Sept 2016).	☑
31634	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed	Feb 2010	Bronchoscopy with Balloon Occlusion	7	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
31647	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31648	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31649	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), each additional lobe (list separately in addition to code for primary procedure)	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
31651	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, when performed, assessment of air leak, airway sizing, and insertion of bronchial valve(s), each additional lobe (list separately in addition to code for primary procedure[s])	Apr 2012	Bronchial Valve Procedures	09	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
31652	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
31653	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (ebus) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
31654	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transendoscopic endobronchial ultrasound (ebus) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (list separately in addition to code for primary procedure[s])	Jan 2015	Endobronchial Ultrasound (EBUS)	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
32553	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-thoracic, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
32701	Thoracic target(s) delineation for stereotactic body radiation therapy (srs/sbrt), (photon or particle beam), entire course of treatment	Jan 2012	Stereotactic Body Radiation	07	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
32994	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; cryoablation	Jan 2017	Cryoablation of Pulmonary Tumors	08	CPT 2018	April 2022		☐
32998	Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, including imaging guidance when performed, unilateral; radiofrequency	Apr 2006	Percutaneous RF Pulmonary Tumor Ablation	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
33254	Operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure)	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33255	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33256	Operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure); with cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33257	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), limited (eg, modified maze procedure) (list separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33258	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), without cardiopulmonary bypass (list separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33259	Operative tissue ablation and reconstruction of atria, performed at the time of other cardiac procedure(s), extensive (eg, maze procedure), with cardiopulmonary bypass (list separately in addition to code for primary procedure)	Apr 2007	Add-on Maze Procedures	23	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33265	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, limited (eg, modified maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33266	Endoscopy, surgical; operative tissue ablation and reconstruction of atria, extensive (eg, maze procedure), without cardiopulmonary bypass	Apr 2006	Atrial Tissue Ablation and Reconstruction	17	CPT 2007	September 2011	Remove, code does not need to be re-evaluated	☑
33267	Exclusion of left atrial appendage, open, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	January 2026		☐
33268	Exclusion of left atrial appendage, open, performed at the time of other sternotomy or thoracotomy procedure(s), any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip) (list separately in addition to code for primary procedure)	Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	January 2026		☐
33269	Exclusion of left atrial appendage, thoracoscopic, any method (eg, excision, isolation via stapling, oversewing, ligation, plication, clip)	Oct 2020	Exclusion of Left Atrial Appendage	05	CPT 2022	January 2026		☐
33270	Insertion or replacement of permanent subcutaneous implantable defibrillator system, with subcutaneous electrode, including defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters, when performed	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33271	Insertion of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33272	Removal of subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33273	Repositioning of previously implanted subcutaneous implantable defibrillator electrode	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33274	Transcatheter insertion or replacement of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography) and device evaluation (eg, interrogation or programming), when performed	Jan 2018	Leadless Pacemaker Procedures	07	CPT 2019	January 2023		☐
33275	Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed	Jan 2018	Leadless Pacemaker Procedures	07	CPT 2019	January 2023		☐
33285	Insertion, subcutaneous cardiac rhythm monitor, including programming	Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	January 2023		☐
33286	Removal, subcutaneous cardiac rhythm monitor	Apr 2017	Cardiac Event Recorder Procedures	07	CPT 2019	January 2023		☐
33289	Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed	Jan 2018	Pulmonary Wireless Pressure Sensor Services	08	CPT 2019	January 2023		☐
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation	Jan 2016	Closure Left Atrial Appendage with Endocardial Implant	10	CPT 2017	January 2023	Review in two years (January 2023); new FDA indication recently released, suggesting this service is still changing.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33361	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; percutaneous femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33362	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open femoral artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33363	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open axillary artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33364	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; open iliac artery approach	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33365	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; transaortic approach (eg, median sternotomy, mediastinotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐
33366	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; transapical exposure (eg, left thoracotomy)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	January 2024	Surveyed again in April 2018 and the RUC indicated that CPT codes 33361, 33362, 33363, 33364, 33365 and 33366 will remain on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33367	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (list separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑
33368	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (list separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑
33369	Transcatheter aortic valve replacement (tavr/tavi) with prosthetic valve; cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (list separately in addition to code for primary procedure)	Apr 2012	Transcatheter Aortic Valve Replacement	12	CPT 2013	October 2016	The Workgroup did not believe there would be a change in physician work or practice expense for the add-on services and recommends that 33367, 33368 and 33369 be removed from the new technology list as there is no demonstrated diffusion.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33370	Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (list separately in addition to code for primary procedure)	Jan 2021	Percutaneous Cerebral Embolic Protection	07	CPT 2022	January 2026		☐
33412	Replacement, aortic valve; with transventricular aortic annulus enlargement (konno procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	January 2023	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	☐
33413	Replacement, aortic valve; by translocation of autologous pulmonary valve with allograft replacement of pulmonary valve (ross procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	January 2023	In the NPRM for 2019 CMS requested that codes 33412 and 33413 should be reviewed when the new code is reviewed for new technology.	☐
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	Apr 2014	Transcatheter Mitral Valve Repair	10	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (list separately in addition to code for primary procedure)	Apr 2014	Transcatheter Mitral Valve Repair	10	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
33440	Replacement, aortic valve; by translocation of autologous pulmonary valve and transventricular aortic annulus enlargement of the left ventricular outflow tract with valved conduit replacement of pulmonary valve (ross-konno procedure)	Jan 2018	Aortoventriculoplasty with Pulmonary Autograft	05	CPT 2019	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33477	Transcatheter pulmonary valve implantation, percutaneous approach, including pre-stenting of the valve delivery site, when performed	Jan 2015	Transcatheter Pulmonary Valve Implantation	06	CPT 2016	January 2023	Review in 3 years (January 2023); pediatric procedure with some CMS utilization.	☑
33509	Harvest of upper extremity artery, 1 segment, for coronary artery bypass procedure, endoscopic	Jan 2021	Harvest of Upper Extremity Artery, Endoscopic and Open	09	CPT 2022	January 2026		☐
33620	Application of right and left pulmonary artery bands (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑
33621	Transthoracic insertion of catheter for stent placement with catheter removal and closure (eg, hybrid approach stage 1)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑
33622	Reconstruction of complex cardiac anomaly (eg, single ventricle or hypoplastic left heart) with palliation of single ventricle with aortic outflow obstruction and aortic arch hypoplasia, creation of cavopulmonary anastomosis, and removal of right and left pulmonary bands (eg, hybrid approach stage 2, norwood, bidirectional glenn, pulmonary artery debanding)	Feb 2010	Cardiac Hybrid Procedures	8	CPT 2011	September 2014	Develop CPT Assitant article to clarify who should report these services. The STS noted and the RUC agreed that only pediatric cardiac surgeons perform 33620 and 33622.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33864	Ascending aorta graft, with cardiopulmonary bypass with valve suspension, with coronary reconstruction and valve-sparing aortic root remodeling (eg, david procedure, yacoub procedure)	Apr 2007	Valve Sparing Aortic Annulus Reconstruction	24	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
33866	Aortic hemiarch graft including isolation and control of the arch vessels, beveled open distal aortic anastomosis extending under one or more of the arch vessels, and total circulatory arrest or isolated cerebral perfusion (list separately in addition to code for primary procedure)	Oct 2018	Aortic Graft Procedures	06	CPT 2020	January 2024		☐
338X3		Oct 2021	Endovascular Pulmonary Arterial Revascularization	04	CPT 2023	January 2027		☐
338X4		Oct 2021	Endovascular Pulmonary Arterial Revascularization	04	CPT 2023	January 2027		☐
338X5		Oct 2021	Endovascular Pulmonary Arterial Revascularization	04	CPT 2023	January 2027		☐
338X6		Oct 2021	Endovascular Pulmonary Arterial Revascularization	04	CPT 2023	January 2027		☐
338X7		Oct 2021	Endovascular Pulmonary Arterial Revascularization	04	CPT 2023	January 2027		☐
33927	Implantation of a total replacement heart system (artificial heart) with recipient cardiectomy	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	April 2022		☐
33928	Removal and replacement of total replacement heart system (artificial heart)	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	April 2022		☐
33929	Removal of a total replacement heart system (artificial heart) for heart transplantation (list separately in addition to code for primary procedure)	Jan 2017	Artifical Heart System Procedure	09	CPT 2018	April 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33946	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; initiation, veno-venous	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33947	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; initiation, veno-arterial	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33948	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; daily management, each day, veno-venous	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33949	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; daily management, each day, veno-arterial	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33951	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33952	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33953	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33954	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33955	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33956	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33957	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33958	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33959	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33962	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition peripheral (arterial and/or venous) cannula(e), open, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33963	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33964	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; reposition central cannula(e) by sternotomy or thoracotomy, 6 years and older (includes fluoroscopic guidance, when performed)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33965	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33966	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), percutaneous, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33969	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33984	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of peripheral (arterial and/or venous) cannula(e), open, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33985	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33986	Extracorporeal membrane oxygenation (ecmo)/extracorporeal life support (ecls) provided by physician; removal of central cannula(e) by sternotomy or thoracotomy, 6 years and older	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33987	Arterial exposure with creation of graft conduit (eg, chimney graft) to facilitate arterial perfusion for ecmo/ecls (list separately in addition to code for primary procedure)	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33988	Insertion of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ecmo/ecls	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
33989	Removal of left heart vent by thoracic incision (eg, sternotomy, thoracotomy) for ecmo/ecls	Apr 2014	ECMO-ECLS	11	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
33995	Insertion of ventricular assist device, percutaneous, including radiological supervision and interpretation; right heart, venous access only	Oct 2019	Percutaneous Ventricular Assist Device Insertion	05	CPT 2021	January 2025		☐
33997	Removal of percutaneous right heart ventricular assist device, venous cannula, at separate and distinct session from insertion	Oct 2019	Percutaneous Ventricular Assist Device Insertion	05	CPT 2021	January 2025		☐
34806	Code Deleted CPT 2008	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	April 2022		☐
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	April 2022		☐
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Jan 2016	Mechanochemical (MOCA) Vein Ablation	13	CPT 2017	April 2022	Review in January 2022 with the other codes in this family identified via the 2022 new technology/new services screen (36475-36479).	☐
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)	Jan 2016	Mechanochemical (MOCA) Vein Ablation	13	CPT 2017	April 2022	Review in January 2022 with the other codes in this family identified via the 2022 new technology/new services screen (36475-36479).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	Apr 2014	Endovenous Ablation	38	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)	Apr 2014	Endovenous Ablation	38	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	Apr 2014	Endovenous Ablation	38	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)	Apr 2014	Endovenous Ablation	38	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	April 2022		☐
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)	Jan 2017	Treatment of Incompetent Veins	11	CPT 2018	April 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
37192	Repositioning of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
37193	Retrieval (removal) of intravascular vena cava filter, endovascular approach including vascular access, vessel selection, and radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy), when performed	Apr 2011	IVC Transcatheter Procedure	12	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
37218	Transcatheter placement of intravascular stent(s), intrathoracic common carotid artery or innominate artery, open or percutaneous antegrade approach, including angioplasty, when performed, and radiological supervision and interpretation	Apr 2014	Transcatheter Placement of Carotid Stents	12	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
38220	Diagnostic bone marrow; aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	April 2022		☐
38221	Diagnostic bone marrow; biopsy(ies)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	April 2022		☐
38222	Diagnostic bone marrow; biopsy(ies) and aspiration(s)	Apr 2016	Diagnostic Bone Marrow Aspiration and Bone Biopsy	06	CPT 2018	April 2022		☐
38900	Intraoperative identification (eg, mapping) of sentinel lymph node(s) includes injection of non-radioactive dye, when performed (list separately in addition to code for primary procedure)	Apr 2010	Sentinel Lymph Node Mapping	8	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
43180	Esophagoscopy, rigid, transoral with diverticulectomy of hypopharynx or cervical esophagus (eg, zenker's diverticulum), with cricopharyngeal myotomy, includes use of telescope or operating microscope and repair, when performed	Jan 2014	Endoscopic Hypopharyngeal Diverticulotomy	7	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43210	Esophagogastroduodenoscopy, flexible, transoral; with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed	Apr 2015	Esophagogatric Fundoplasty Trans-Oral Approach	05	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
43273	Endoscopic cannulation of papilla with direct visualization of pancreatic/common bile duct(s) (list separately in addition to code(s) for primary procedure)	Apr 2008	Cholangioscopy-Pancreatoscopy	13	CPT 2009	September 2012	Specialty to survey Feb 2013 with family of services	☑
43279	Laparoscopy, surgical, esophagomyotomy (heller type), with fundoplasty, when performed	Apr 2008	Laparoscopic Heller Myotomy	12	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
43281	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; without implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
43282	Laparoscopy, surgical, repair of paraesophageal hernia, includes fundoplasty, when performed; with implantation of mesh	Apr 2009	Laparoscopic Paraesophageal Hernia Repair	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43284	Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band), including cruroplasty when performed	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	January 2024	Review in 3 years (January 2024). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.	☐
43285	Removal of esophageal sphincter augmentation device	Jan 2016	Esophageal Sphincter Augmentation	17	CPT 2017	January 2024	Review in 3 years (January 2024). The initial RUC survey was insufficient in number of respondents and RUC recommended re-surveying when volume is sufficient. Even though the typical patient is below Medicare age, society believes volumes remain low. Utilization of the removal code 43285 is higher than expected suggesting the services may be reported inappropriately.	☐
43497	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [poem])	Oct 2020	Per-Oral Endoscopic Myotomy (POEM)	07	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
43647	Laparoscopy, surgical; implantation or replacement of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43648	Laparoscopy, surgical; revision or removal of gastric neurostimulator electrodes, antrum	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43775	Laparoscopy, surgical, gastric restrictive procedure; longitudinal gastrectomy (ie, sleeve gastrectomy)	Apr 2009	Laparoscopic Longitudinal Gastrectomy	14	CPT 2010	September 2013	Remove from list, carrier priced.	☑
43881	Implantation or replacement of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43882	Revision or removal of gastric neurostimulator electrodes, antrum, open	Apr 2006	Gastric Antrum Neurostimulation	26	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
43X21		Apr 2021	Endoscopic Bariatric Device Procedures	08	CPT 2023	January 2027		☐
43X22		Apr 2021	Endoscopic Bariatric Device Procedures	08	CPT 2023	January 2027		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
44705	Preparation of fecal microbiota for instillation, including assessment of donor specimen	Apr 2012	Fecal Bacteriotherapy	18	CPT 2013	October 2018	The specialty societies indicated that they tried to develop a category I code to replace 44705 which is not currently covered by Medicare, but the CPT Editorial Panel did not accept the coding change proposal due to a lack in literature provided. The Workgroup recommended that these services be reviewed in 2 year after additional utilization data is available (October 2018). In Octobre 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
46601	Anoscopy; diagnostic, with high-resolution magnification (hra) (eg, colposcope, operating microscope) and chemical agent enhancement, including collection of specimen(s) by brushing or washing, when performed	Apr 2014	High Resolution Anoscopy	14	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
46607	Anoscopy; with high-resolution magnification (hra) (eg, colposcope, operating microscope) and chemical agent enhancement, with biopsy, single or multiple	Apr 2014	High Resolution Anoscopy	14	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data and to determine what specialties are performing this service (2022).	☐
46707	Repair of anorectal fistula with plug (eg, porcine small intestine submucosa [sis])	Apr 2009	Fistula Plug	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
46948	Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance, with mucopexy, when performed	Oct 2018	Transanal Hemorrhoidal Dearterialization	07	CPT 2020	January 2024		☐
47383	Ablation, 1 or more liver tumor(s), percutaneous, cryoablation	Apr 2014	Cryoablation of Liver Tumor	15	CPT 2015	October 2018	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
49327	Laparoscopy, surgical; with placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), intra-abdominal, intrapelvic, and/or retroperitoneum, including imaging guidance, if performed, single or multiple (list separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
49411	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple	Apr 2009	Fiducial Marker Placement	6	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
49412	Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), open, intra-abdominal, intrapelvic, and/or retroperitoneum, including image guidance, if performed, single or multiple (list separately in addition to code for primary procedure)	Apr 2010	Fiducial Marker Placement	10	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
49652	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49653	Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49654	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2009	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
49655	Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated	Feb 2011	Laparoscopic Hernia Repair	30	CPT 2012	October 2015	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
50430	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; new access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50432	Placement of nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50433	Placement of nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, new access	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50434	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, via pre-existing nephrostomy tract	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50435	Exchange nephrostomy catheter, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50593	Ablation, renal tumor(s), unilateral, percutaneous, cryotherapy	Apr 2007	Percutaneous Renal Tumor Cryotherapy	A	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
50606	Endoluminal biopsy of ureter and/or renal pelvis, non-endoscopic, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50693	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; pre-existing nephrostomy tract	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50694	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, without separate nephrostomy catheter	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50695	Placement of ureteral stent, percutaneous, including diagnostic nephrostogram and/or ureterogram when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; new access, with separate nephrostomy catheter	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50705	Ureteral embolization or occlusion, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
50706	Balloon dilation, ureteral stricture, including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation (list separately in addition to code for primary procedure)	Apr 2015	Genitourinary Catheter Procedures	08	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
52441	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant	Apr 2014	Cystourethroscopy Insertion Transprostatic Implant	16	CPT 2015	October 2018	Survey for January 2019	☑
52442	Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (list separately in addition to code for primary procedure)	Apr 2014	Cystourethroscopy Insertion Transprostatic Implant	16	CPT 2015	October 2018	Survey for January 2019	☑
53854	Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy	Jan 2018	Transurethral Destruction of Prostate Tissue	13	CPT 2019	January 2023		☐
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	Feb 2009	Temporary Prostatic Urethral Stent Insertion	12	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
53860	Transurethral radiofrequency micro-remodeling of the female bladder neck and proximal urethra for stress urinary incontinence	Apr 2010	Transurethral Radiofrequency Bladder Neck and Urethra	12	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
55706	Biopsies, prostate, needle, transperineal, stereotactic template guided saturation sampling, including imaging guidance	Apr 2008	Saturation Biopsies	15	CPT 2009	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed	Oct 2009	Laparoscopic Radical Prostatectomy	14	CPT 2011	September 2014	Survey for April 2015. Specialty society should consider surveying 55845 and 55866 at the same time.	☑
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed	Jan 2017	Peri-Prostatic Implantation of Biodegradable Material	13	CPT 2018	April 2022		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
55880	Ablation of malignant prostate tissue, transrectal, with high intensity-focused ultrasound (hifu), including ultrasound guidance	Oct 2019	Transrectal High Intesity Focused US Prostate Ablation	06	CPT 2021	January 2025		☐
57423	Paravaginal defect repair (including repair of cystocele, if performed), laparoscopic approach	Apr 2007	Laparoscopic Paravaginal Defect Repair	C	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
57425	Laparoscopy, surgical, colpopexy (suspension of vaginal apex)	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach	Oct 2008	Laparoscopic Revision of Prosthetic Vaginal Graft	7	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
57465	Computer-aided mapping of cervix uteri during colposcopy, including optical dynamic spectral imaging and algorithmic quantification of the acetowhitening effect (list separately in addition to code for primary procedure)	Jan 2020	Computer-Aided Mapping of Cervix Uteri	14	CPT 2021	January 2025		☐
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Feb 2006	Laparoscopic Supracervical Hysterectomy	13	CPT 2007	September 2013	Survey April 2014	☑
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)	Apr 2007	Laparoscopic Total Hysterectomy	D	CPT 2008	September 2013	Survey April 2014	☑
58674	Laparoscopy, surgical, ablation of uterine fibroid(s) including intraoperative ultrasound guidance and monitoring, radiofrequency	Jan 2016	Laparoscopic Radiofrequency Ablation of Uterine Fibroids	18	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
61645	Percutaneous arterial transluminal mechanical thrombectomy and/or infusion for thrombolysis, intracranial, any method, including diagnostic angiography, fluoroscopic guidance, catheter placement, and intraprocedural pharmacological thrombolytic injection(s)	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑
61650	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; initial vascular territory	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
61651	Endovascular intracranial prolonged administration of pharmacologic agent(s) other than for thrombolysis, arterial, including catheter placement, diagnostic angiography, and imaging guidance; each additional vascular territory (list separately in addition to code for primary procedure)	Apr 2015	Intracranial Endovascular Intervention	09	CPT 2016	October 2019	Remove from list. Although the RUC discussed that the subsequent hostial visit occurs, CMS has already issued their statement on 23-hr hospital stay services.	☑
61736	Laser interstitial thermal therapy (litt) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	Jan 2021	Intracranial Laser Interstitial Thermal Therapy (LITT)	12	CPT 2022	January 2026		☐
61737	Laser interstitial thermal therapy (litt) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	Jan 2021	Intracranial Laser Interstitial Thermal Therapy (LITT)	12	CPT 2022	January 2026		☐
62328	Spinal puncture, lumbar, diagnostic; with fluoroscopic or ct guidance	Jan 2019	Lumbar Puncture	09	CPT 2020	January 2024		☐
62329	Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or ct guidance	Jan 2019	Lumbar Puncture	09	CPT 2020	January 2024		☐
62380	Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar	Jan 2016	Endoscopic Decompression of Spinal Cord Nerve	19	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
63620	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
63621	Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); each additional spinal lesion (list separately in addition to code for primary procedure)	Apr 2008	Stereotactic Radiosurgery	16	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	Jan 2019	Genicular Injection and RFA	10	CPT 2020	January 2024		☐
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Jan 2019	Radiofrequency Neurotomy Sacroiliac Joint	08	CPT 2020	January 2024		☐
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	Jan 2019	Genicular Injection and RFA	10	CPT 2020	January 2024		☐
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming	Apr 2010	Posterior Tibial Nerve Stimulation	13	CPT 2011	October 2019	Surveyed for April 2015, RUC recommended to review utilization again in 2 years (Oct 2019). In Oct 2019, recommended to remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
64569	Revision or replacement of cranial nerve (eg, vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
64570	Removal of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Feb 2010	Vagus Nerve Stimulator	14	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
64624	Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed	Jan 2019	Genicular Injection and RFA	10	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Jan 2019	Radiofrequency Neurotomy Sacroiliac Joint	08	CPT 2020	January 2024		☐
64628	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; first 2 vertebral bodies, lumbar or sacral	Jan 2021	Destruction of Intraosseous Basivertebral Nerve	14	CPT 2022	January 2026		☐
64629	Thermal destruction of intraosseous basivertebral nerve, including all imaging guidance; each additional vertebral body, lumbar or sacral (list separately in addition to code for primary procedure)	Jan 2021	Destruction of Intraosseous Basivertebral Nerve	14	CPT 2022	January 2026		☐
64640	Destruction by neurolytic agent; other peripheral nerve or branch	Jan 2019	Genicular Injection and RFA	10	CPT 2020	January 2024		☐
65756	Keratoplasty (corneal transplant); endothelial	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated. Though volume grew faster than expected, there was a decrease in other services of similar magnitude, that were previously reported and had similar work RVUs. All remained work neutral.	☑
65757	Backbench preparation of corneal endothelial allograft prior to transplantation (list separately in addition to code for primary procedure)	Apr 2008	Endothelial Keratoplasty	20	CPT 2009	September 2012	Remove, code does not need to be re-evaluated.	☑
65778	Placement of amniotic membrane on the ocular surface; without sutures	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014	Survey for April 2015.	☑
65779	Placement of amniotic membrane on the ocular surface; single layer, sutured	Feb 2010	Amniotic Membrane Placement	15	CPT 2011	September 2014	Survey for April 2015.	☑
65780	Ocular surface reconstruction; amniotic membrane transplantation, multiple layers	Oct 2011	Relativity Assessment Workgroup	51	CPT 2011	September 2014	Survey for April 2015.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
65785	Implantation of intrastromal corneal ring segments	Jan 2015	Intrastomal Corneal Ring Implantation	11	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
66174	Transluminal dilation of aqueous outflow canal; without retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	October 2019	Jan 2020 - Referred to CPT	☑
66175	Transluminal dilation of aqueous outflow canal; with retention of device or stent	Apr 2010	Open Angle Glaucoma Procedures	15	CPT 2011	October 2019	Jan 2020 - Referred to CPT	☑
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach	Apr 2013	Insertion of Anterior Segment	14	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐
66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐
66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more	Jan 2021	Cataract Removal with Drainage Device Insertion	16	CPT 2022	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
68816	Probing of nasolacrimal duct, with or without irrigation; with transluminal balloon catheter dilation	Apr 2007	Nasolacrimal Duct Balloon Catheter Dilation	E	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
68841	Insertion of drug-eluting implant, including punctal dilation when performed, into lacrimal canaliculus, each	Jan 2021	Lacrimal Canaliculus Drug Eluting Implant Insertion	17	CPT 2022	January 2026		☐
69705	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); unilateral	Jan 2020	Dilation of Eustachian Tube	15	CPT 2021	January 2025		☐
69706	Nasopharyngoscopy, surgical, with dilation of eustachian tube (ie, balloon dilation); bilateral	Jan 2020	Dilation of Eustachian Tube	15	CPT 2021	January 2025		☐
70554	Magnetic resonance imaging, brain, functional mri; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
70555	Magnetic resonance imaging, brain, functional mri; requiring physician or psychologist administration of entire neurofunctional testing	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	Oct 2019	Screening CT of Thorax	07	CPT 2021	January 2025		☐
74261	Computed tomographic (ct) colonography, diagnostic, including image postprocessing; without contrast material	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
74262	Computed tomographic (ct) colonography, diagnostic, including image postprocessing; with contrast material(s) including non-contrast images, if performed	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
74263	Computed tomographic (ct) colonography, screening, including image postprocessing	Apr 2009	CT Colonography	19	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75557	Cardiac magnetic resonance imaging for morphology and function without contrast material;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75558.	☑
75558	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75559	Cardiac magnetic resonance imaging for morphology and function without contrast material; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
75560	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75561	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, as utilization is appropriate due to shift of utilization for deleted code which included "with flow/velocity quantification", code 75560.	☑
75562	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
75564	Code Deleted CPT 2010	Apr 2007	Cardiac MRI	F	CPT 2008	September 2011	Code Deleted CPT 2010	☑
75571	Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75572	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology (including 3d image postprocessing, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75573	Computed tomography, heart, with contrast material, for evaluation of cardiac structure and morphology in the setting of congenital heart disease (including 3d image postprocessing, assessment of left ventricular [lv] cardiac function, right ventricular [rv] structure and function and evaluation of vascular structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
75574	Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3d image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)	Feb 2009	Coronary Computed Tomographic Angiography	15	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
76391	Magnetic resonance (eg, vibration) elastography	Jan 2018	Magnetic Resonance Elastography	16	CPT 2019	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76881	Ultrasound, complete joint (ie, joint space and peri-articular soft-tissue structures), real-time with image documentation	Apr 2010	Ultrasound of Extremity	17	CPT 2011	January 2022	The specialty society noted and the Workgroup agreed that the dominant specialties providing the complete versus the limited ultrasound of extremity services are different. Thus, causing variation in what the typical practice expense inputs. The Workgroup recommends to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019). In Oct 2019, the RAW recommended to review in 2 years after additional utilization data is available. These services were revised at the October 2021 CPT meeting and will be surveyed.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76882	Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation	Apr 2010	Ultrasound of Extremity	17	CPT 2011	January 2022	The specialty society noted and the Workgroup agreed that the dominant specialties providing the complete versus the limited ultrasound of extremity services are different. Thus, causing variation in what the typical practice expense inputs. The Workgroup recommends to 1) Refer CPT codes 76881 and 76882 to the Practice Expense Subcommittee for review of the direct practice expense inputs; 2) Refer to the CPT Editorial Panel to clarify the introductory language regarding the reference to one joint in the complete ultrasound; and 3) Review again in 3 years (October 2019). In Oct 2019, the RAW recommended to review in 2 years after additional utilization data is available. These services were revised at the October 2021 CPT meeting and will be surveyed.	☐
76978	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); initial lesion	Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
76979	Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection (list separately in addition to code for primary procedure)	Jan 2018	Contrast-Enhanced Ultrasound	15	CPT 2019	January 2023		☐
76981	Ultrasound, elastography; parenchyma (eg, organ)	Jan 2018	Ultrasound Elastography	14	CPT 2019	January 2023		☐
76982	Ultrasound, elastography; first target lesion	Jan 2018	Ultrasound Elastography	14	CPT 2019	January 2023		☐
76983	Ultrasound, elastography; each additional target lesion (list separately in addition to code for primary procedure)	Jan 2018	Ultrasound Elastography	14	CPT 2019	January 2023		☐
77021	Magnetic resonance imaging guidance for needle placement (eg, for biopsy, needle aspiration, injection, or placement of localization device) radiological supervision and interpretation	Jan 2018	Fine Needle Aspiration	04	CPT 2019	January 2023		☐
77046	Magnetic resonance imaging, breast, without contrast material; unilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	January 2023		☐
77047	Magnetic resonance imaging, breast, without contrast material; bilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	January 2023		☐
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (cad real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	January 2023		☐
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (cad real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	Oct 2017	Breast MRI with Computer-Aided Detection	06	CPT 2019	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77061	Diagnostic digital breast tomosynthesis; unilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	April 2022	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2022).	☐
77062	Diagnostic digital breast tomosynthesis; bilateral	Apr 2014	Breast Tomosynthesis	19	CPT 2015	April 2022	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2022).	☐
77063	Screening digital breast tomosynthesis, bilateral (list separately in addition to code for primary procedure)	Apr 2014	Breast Tomosynthesis	19	CPT 2015	April 2022	In October 2018, the RUC recommended that CMS delete G0279 amd ise codes 77061, 77062 and 77063 as created by CPT and valued by the RUC. Review again in 3 years (2022).	☐
77089	Trabecular bone score (tbs), structural condition of the bone microarchitecture; using dual x-ray absorptiometry (dxa) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture-risk	Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐
77090	Trabecular bone score (tbs), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere	Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77091	Trabecular bone score (tbs), structural condition of the bone microarchitecture; technical calculation only	Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐
77092	Trabecular bone score (tbs), structural condition of the bone microarchitecture; interpretation and report on fracture-risk only by other qualified health care professional	Jan 2021	Trabecular Bone Score (TBS)	19	CPT 2022	January 2026		☐
77293	Respiratory motion management simulation (list separately in addition to code for primary procedure)	Jan 2013	Respiratory Motion Management Simulation	14	CPT 2014	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
77371	Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source cobalt 60 based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
77372	Radiation treatment delivery, stereotactic radiosurgery (srs), complete course of treatment of cranial lesion(s) consisting of 1 session; linear accelerator based	Sep 2005	Stereotactic Radiation Tx Delivery	7	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
77373	Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Practice expense review (Feb 2011).	☑
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Apr 2006	Stereotactic Body Radiation Therapy	B	CPT 2007	September 2010	Survey (work) and PE review (Feb 2011).	☑
77435	Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions	Feb 2011	Stereotactic Body Radiation Delivery	32	CPT 2012	October 2015	Practice expense review (Feb 2011).	☑
77520	Proton treatment delivery; simple, without compensation	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
77522	Proton treatment delivery; simple, with compensation	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐
77523	Proton treatment delivery; intermediate	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐
77525	Proton treatment delivery; complex	Apr 2019	Proton Beam Treatment Delivery (PE Only)	19	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78071	Parathyroid planar imaging (including subtraction, when performed); with tomographic (spect)	Apr 2012	Parathyroid Imaging	23	CPT 2013	October 2018	In April 2011, CPT Code 78007, Thyroid imaging, with uptake; multiple determinations was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology. AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. It appeared that was only one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected. The specialty societies submitted an action plan indicating that literature supporting parathyroid scintigraphy as an	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be postponed and reviewed in 2 years	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							after the CPT Assistant article is published. In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78072	Parathyroid planar imaging (including subtraction, when performed); with tomographic (spect), and concurrently acquired computed tomography (ct) for anatomical localization	Apr 2012	Parathyroid Imaging	23	CPT 2013	October 2018	In April 2011, CPT Code 78007, Thyroid imaging, with uptake; multiple determinations was identified in the Harvard Valued-Utilization over 30,000 screen. As part of the review of the entire endocrine family, the specialty societies determined that revisions to the parathyroid imaging procedures were necessary to reflect current bundling policies, guideline changes and new technology. AMA Staff reviewed the work neutrality impacts for codes reviewed in the CPT 2013 cycle. It appeared that was only one issue where there was a large growth in utilization in the first year. For CPT 2013 the Parathyroid Imaging codes were not work neutral, and it was initially estimated as a savings overall. It appears that there was 40% increase from what was projected. The specialty societies submitted an action plan indicating that literature supporting parathyroid scintigraphy as an	☑

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							effective diagnostic study for parathyroid disease has recently emerged and supports the clinical utility thus increasing utilization. Secondly, the availability of SPECT/CT cameras has increased and is greater than initially predicted, allowing for a higher utilization. The Workgroup agreed and also noted that these services are conducted on patients who are referred to the radiologists or nuclear medicine physicians. The physicians providing these services do not control the number of patients referred to them who receive these services. The Workgroup recommends that the specialty societies develop a CPT Assistant article to address potential current use of 78803 rather than the new codes 78071 and 78072. The Workgroup noted that these services are on the new technology list for review later this year and should be postponed and reviewed in 2 years	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							after the CPT Assistant article is published. In October 2018, the RUC recommended to remove from list , no demonstrated technology diffusion that impacts work or practice expense.	
78265	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel transit	Apr 2015	Colon Transit Imaging	18	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
78266	Gastric emptying imaging study (eg, solid, liquid, or both); with small bowel and colon transit, multiple days	Apr 2015	Colon Transit Imaging	18	CPT 2016	October 2019	Remove from list , no demonstrated technology diffusion that impacts work or practice expense.	☑
78429	Myocardial imaging, positron emission tomography (pet), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78430	Myocardial imaging, positron emission tomography (pet), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78431	Myocardial imaging, positron emission tomography (pet), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78432	Myocardial imaging, positron emission tomography (pet), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability);	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78433	Myocardial imaging, positron emission tomography (pet), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78434	Absolute quantitation of myocardial blood flow (aqmbf), positron emission tomography (pet), rest and pharmacologic stress (list separately in addition to code for primary procedure)	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78459	Myocardial imaging, positron emission tomography (pet), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study;	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78491	Myocardial imaging, positron emission tomography (pet), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78492	Myocardial imaging, positron emission tomography (pet), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); multiple studies at rest and stress (exercise or pharmacologic)	Jan 2019	Myocardial PET	13	CPT 2020	January 2024		☐
78811	Positron emission tomography (pet) imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78812	Positron emission tomography (pet) imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78813	Positron emission tomography (pet) imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78814	Positron emission tomography (pet) with concurrently acquired computed tomography (ct) for attenuation correction and anatomical localization imaging; limited area (eg, chest, head/neck)	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78815	Positron emission tomography (pet) with concurrently acquired computed tomography (ct) for attenuation correction and anatomical localization imaging; skull base to mid-thigh	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78816	Positron emission tomography (pet) with concurrently acquired computed tomography (ct) for attenuation correction and anatomical localization imaging; whole body	Apr 2007	PET Imaging	G	CPT 2008	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
78830	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (spect) with concurrently acquired computed tomography (ct) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging	Jan 2019	SPECT-CT Procedures	14	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
78831	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (spect), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	Jan 2019	SPECT-CT Procedures	14	CPT 2020	January 2024		☐
78832	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (spect) with concurrently acquired computed tomography (ct) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days	Jan 2019	SPECT-CT Procedures	14	CPT 2020	January 2024		☐
78835	Radiopharmaceutical quantification measurement(s) single area (list separately in addition to code for primary procedure)	Jan 2019	SPECT-CT Procedures	14	CPT 2020	January 2024		☐
81161	Dmd (dystrophin) (eg, duchenne/becker muscular dystrophy) deletion analysis, and duplication analysis, if performed	Oct 2012	Molecular Pathology -Tier 1	11	CPT 2014	October 2017	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81201	Apc (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [fap], attenuated fap) gene analysis; full gene sequence	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81202	Apc (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [fap], attenuated fap) gene analysis; known familial variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81203	Apc (adenomatous polyposis coli) (eg, familial adenomatosis polyposis [fap], attenuated fap) gene analysis; duplication/deletion variants	Apr 2012	Molecular Pathology-Adenomatous Polyposis Coli	24	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81206	Bcr/abl1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81207	Bcr/abl1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81208	Bcr/abl1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81210	Braf (b-raf proto-oncogene, serine/threonine kinase) (eg, colon cancer, melanoma), gene analysis, v600 variant(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81216	Brca2 (brca2, dna repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81217	Brca2 (brca2, dna repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; known familial variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81220	Cftr (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; common variants (eg, acmg/acog guidelines)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81221	Cftr (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; known familial variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81222	Cftr (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; duplication/deletion variants	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81223	Cftr (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; full gene sequence	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81224	Cftr (cystic fibrosis transmembrane conductance regulator) (eg, cystic fibrosis) gene analysis; intron 8 poly-t analysis (eg, male infertility)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81225	Cyp2c19 (cytochrome p450, family 2, subfamily c, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81227	Cyp2c9 (cytochrome p450, family 2, subfamily c, polypeptide 9) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *5, *6)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81235	Egfr (epidermal growth factor receptor) (eg, non-small cell lung cancer) gene analysis, common variants (eg, exon 19 lrea deletion, l858r, t790m, g719a, g719s, l861q)	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81240	F2 (prothrombin, coagulation factor ii) (eg, hereditary hypercoagulability) gene analysis, 20210g>a variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81241	F5 (coagulation factor v) (eg, hereditary hypercoagulability) gene analysis, leiden variant	Apr 2011	Molecular Pathology Test - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81243	Fmr1 (fragile x mental retardation 1) (eg, fragile x mental retardation) gene analysis; evaluation to detect abnormal (eg, expanded) alleles	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81244	Fmr1 (fragile x mental retardation 1) (eg, fragile x mental retardation) gene analysis; characterization of alleles (eg, expanded size and promoter methylation status)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81245	Flt3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia), gene analysis; internal tandem duplication (itd) variants (ie, exons 14, 15)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81252	Gjb2 (gap junction protein, beta 2, 26kda, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; full gene sequence	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81253	Gjb2 (gap junction protein, beta 2, 26kda, connexin 26) (eg, nonsyndromic hearing loss) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81254	Gjb6 (gap junction protein, beta 6, 30kda, connexin 30) (eg, nonsyndromic hearing loss) gene analysis, common variants (eg, 309kb [del(gjb6-d13s1830)] and 232kb [del(gjb6-d13s1854)])	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81256	Hfe (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, c282y, h63d)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81257	Hba1/hba2 (alpha globin 1 and alpha globin 2) (eg, alpha thalassemia, hb bart hydrops fetalis syndrome, hbh disease), gene analysis; common deletions or variant (eg, southeast asian, thai, filipino, mediterranean, alpha3.7, alpha4.2, alpha20.5, constant spring)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81261	Igh@ (immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, b-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81262	Igh@ (immunoglobulin heavy chain locus) (eg, leukemias and lymphomas, b-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (eg, southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81263	Igh@ (immunoglobulin heavy chain locus) (eg, leukemia and lymphoma, b-cell), variable region somatic mutation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81264	Igk@ (immunoglobulin kappa light chain locus) (eg, leukemia and lymphoma, b-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81265	Comparative analysis using short tandem repeat (str) markers; patient and comparative specimen (eg, pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [eg, buccal swab or other germline tissue sample] and donor testing, twin zygosity testing, or maternal cell contamination of fetal cells)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81266	Comparative analysis using short tandem repeat (str) markers; each additional specimen (eg, additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (list separately in addition to code for primary procedure)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81267	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; without cell selection	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81268	Chimerism (engraftment) analysis, post transplantation specimen (eg, hematopoietic stem cell), includes comparison to previously performed baseline analyses; with cell selection (eg, cd3, cd33), each cell type	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81270	Jak2 (janus kinase 2) (eg, myeloproliferative disorder) gene analysis, p.val617phe (v617f) variant	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81275	Kras (kirsten rat sarcoma viral oncogene homolog) (eg, carcinoma) gene analysis; variants in exon 2 (eg, codons 12 and 13)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81291	Mthfr (5,10-methylenetetrahydrofolate reductase) (eg, hereditary hypercoagulability) gene analysis, common variants (eg, 677t, 1298c)	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81292	Mlh1 (mutl homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81293	Mlh1 (mutl homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81294	Mlh1 (mutl homolog 1, colon cancer, nonpolyposis type 2) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81295	Msh2 (muts homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81296	Msh2 (muts homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81297	Msh2 (muts homolog 2, colon cancer, nonpolyposis type 1) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81298	Msh6 (muts homolog 6 [e. coli]) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81299	Msh6 (muts homolog 6 [e. coli]) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81300	Msh6 (muts homolog 6 [e. coli]) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81301	Microsatellite instability analysis (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) of markers for mismatch repair deficiency (eg, bat25, bat26), includes comparison of neoplastic and normal tissue, if performed	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81302	Mecp2 (methyl cpg binding protein 2) (eg, rett syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81303	Mecp2 (methyl cpg binding protein 2) (eg, rett syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81304	Mecp2 (methyl cpg binding protein 2) (eg, rett syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81315	Pml/raralpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; common breakpoints (eg, intron 3 and intron 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81316	Pml/raralpha, (t(15;17)), (promyelocytic leukemia/retinoic acid receptor alpha) (eg, promyelocytic leukemia) translocation analysis; single breakpoint (eg, intron 3, intron 6 or exon 6), qualitative or quantitative	Apr 2011	Molecular Pathology - Tier 1	15	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81317	Pms2 (postmeiotic segregation increased 2 [s. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81318	Pms2 (postmeiotic segregation increased 2 [s. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; known familial variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81319	Pms2 (postmeiotic segregation increased 2 [s. cerevisiae]) (eg, hereditary non-polyposis colorectal cancer, lynch syndrome) gene analysis; duplication/deletion variants	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81321	Pten (phosphatase and tensin homolog) (eg, cowden syndrome, pten hamartoma tumor syndrome) gene analysis; full sequence analysis	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81322	Pten (phosphatase and tensin homolog) (eg, cowden syndrome, pten hamartoma tumor syndrome) gene analysis; known familial variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81323	Pten (phosphatase and tensin homolog) (eg, cowden syndrome, pten hamartoma tumor syndrome) gene analysis; duplication/deletion variant	Sep 2011	Molecular Pathology Test - Tier 1	09	CPT 2013	October 2016	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81331	Snrpn/ube3a (small nuclear ribonucleoprotein polypeptide n and ubiquitin protein ligase e3a) (eg, prader-willi syndrome and/or angelman syndrome), methylation analysis	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81332	Serpina1 (serpin peptidase inhibitor, clade a, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *s and *z)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81340	Trb@ (t cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (eg, polymerase chain reaction)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81341	Trb@ (t cell antigen receptor, beta) (eg, leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (eg, southern blot)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81342	Trg@ (t cell antigen receptor, gamma) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81350	Ugt1a1 (udp glucuronosyltransferase 1 family, polypeptide a1) (eg, drug metabolism, hereditary unconjugated hyperbilirubinemia [gilbert syndrome]) gene analysis, common variants (eg, *28, *36, *37)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81355	Vkorc1 (vitamin k epoxide reductase complex, subunit 1) (eg, warfarin metabolism), gene analysis, common variant(s) (eg, -1639g>a, c.173+1000c>t)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81370	Hla class i and ii typing, low resolution (eg, antigen equivalents); hla-a, -b, -c, -drb1/3/4/5, and -dqb1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81371	Hla class i and ii typing, low resolution (eg, antigen equivalents); hla-a, -b, and -drb1 (eg, verification typing)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81372	Hla class i typing, low resolution (eg, antigen equivalents); complete (ie, hla-a, -b, and -c)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81373	Hla class i typing, low resolution (eg, antigen equivalents); one locus (eg, hla-a, -b, or -c), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81374	Hla class i typing, low resolution (eg, antigen equivalents); one antigen equivalent (eg, b*27), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81375	Hla class ii typing, low resolution (eg, antigen equivalents); hla-drb1/3/4/5 and -dqb1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81376	Hla class ii typing, low resolution (eg, antigen equivalents); one locus (eg, hla-drb1, -drb3/4/5, -dqb1, -dqa1, -dpb1, or -dpa1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81377	Hla class ii typing, low resolution (eg, antigen equivalents); one antigen equivalent, each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81378	Hla class i and ii typing, high resolution (ie, alleles or allele groups), hla-a, -b, -c, and -drb1	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81379	Hla class i typing, high resolution (ie, alleles or allele groups); complete (ie, hla-a, -b, and -c)	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81380	Hla class i typing, high resolution (ie, alleles or allele groups); one locus (eg, hla-a, -b, or -c), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81381	Hla class i typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, b*57:01p), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81382	Hla class ii typing, high resolution (ie, alleles or allele groups); one locus (eg, hla-drb1, -drb3/4/5, -dqb1, -dqa1, -dpb1, or -dpa1), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑
81383	Hla class ii typing, high resolution (ie, alleles or allele groups); one allele or allele group (eg, hla-dqb1*06:02p), each	Sep 2011	Molecular Pathology Test - Tier 1	05	CPT 2012	October 2015	Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81400	Molecular pathology procedure, level 1 (eg, identification of single germline variant [eg, snp] by techniques such as restriction enzyme digestion or melt curve analysis) acadm (acyl-coa dehydrogenase, c-4 to c-12 straight chain, mcad) (eg, medium chain acyl dehydrogenase deficiency), k304e variant ace (angiotensin converting enzyme) (eg, hereditary blood pressure regulation), insertion/deletion variant agtr1 (angiotensin ii receptor, type 1) (eg, essential hypertension), 1166a>c variant bckdha (branched chain keto acid dehydrogenase e1, alpha polypeptide) (eg, maple syrup urine disease, type 1a), y438n variant ccr5 (chemokine c-c motif receptor 5) (eg, hiv resistance), 32-bp deletion mutation/794 825del32 deletion clrn1 (clarin 1) (eg, usher syndrome, type 3), n48k variant f2 (coagulation factor 2) (eg, hereditary hypercoagulability), 1199g>a variant f5 (coagulation factor v) (eg, hereditary hypercoagulability), hr2 variant f7 (coagulation factor vii [serum prothrombin conversion accelerator]) (eg, hereditary hypercoagulability), r353q variant f13b (coagulation factor xiii, b polypeptide) (eg, hereditary hypercoagulability), v34l variant fgb (fibrinogen beta chain) (eg, hereditary ischemic heart disease), -455g>a variant fgfr1 (fibroblast growth factor receptor 1) (eg, pfeiffer syndrome type 1, craniosynostosis), p252r variant fgfr3 (fibroblast growth factor receptor 3) (eg, muenke syndrome), p250r variant fktn (fukutin) (eg, fukuyama congenital muscular dystrophy), retrotransposon insertion variant gne (glucosamine [udp-n-acetyl]-2-epimerase/n-acetylmannosamine kinase) (eg, inclusion body myopathy 2 [ibm2], nonaka myopathy), m712t variant ivd (isovaleryl-coa dehydrogenase) (eg, isovaleric acidemia), a282v variant lct (lactase-phlorizin hydrolase) (eg, lactose intolerance), 13910 c>t variant neb (nebulin) (eg, nemaline myopathy 2), exon 55 deletion variant pcdh15 (protocadherin-related 15) (eg, usher syndrome type 1f), r245x variant serpine1 (serpine peptidase	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	inhibitor clade e, member 1, plasminogen activator inhibitor -1, pai-1) (eg, thrombophilia), 4g variant shoc2 (soc-2 suppressor of clear homolog) (eg, noonan-like syndrome with loose anagen hair), s2g variant sry (sex determining region y) (eg, 46,xx testicular disorder of sex development, gonadal dysgenesis), gene analysis tor1a (torsin family 1, member a [torsin a]) (eg, early-onset primary dystonia [dyt1]), 907_909delgag (904_906delgag) variant							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81401	Molecular pathology procedure, level 2 (eg, 2-10 snps, 1 methylated variant, or 1 somatic variant [typically using nonsequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) abcc8 (atp-binding cassette, sub-family c [cftr/mrp], member 8) (eg, familial hyperinsulinism), common variants (eg, c.3898-9g>a [c.3992-9g>a], f1388del) abl1 (abl proto-oncogene 1, non-receptor tyrosine kinase) (eg, acquired imatinib resistance), t315i variant acadm (acyl-coa dehydrogenase, c-4 to c-12 straight chain, mcad) (eg, medium chain acyl dehydrogenase deficiency), commons variants (eg, k304e, y42h) adrb2 (adrenergic beta-2 receptor surface) (eg, drug metabolism), common variants (eg, g16r, q27e) apob (apolipoprotein b) (eg, familial hypercholesterolemia type b), common variants (eg, r3500q, r3500w) apoe (apolipoprotein e) (eg, hyperlipoproteinemia type iii, cardiovascular disease, alzheimer disease), common variants (eg, *2, *3, *4) cbfb/myh11 (inv(16)) (eg, acute myeloid leukemia), qualitative, and quantitative, if performed cbs (cystathionine-beta-synthase) (eg, homocystinuria, cystathionine beta-synthase deficiency), common variants (eg, i278t, g307s) cfh/arms2 (complement factor h/age-related maculopathy susceptibility 2) (eg, macular degeneration), common variants (eg, y402h [cfh], a69s [arms2]) dek/nup214 (t(6;9)) (eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed e2a/pbx1 (t(1;19)) (eg, acute lymphocytic leukemia), translocation analysis, qualitative, and quantitative, if performed eml4/alk (inv(2)) (eg, non-small cell lung cancer), translocation or inversion analysis etv6/runx1 (t(12;21)) (eg, acute lymphocytic leukemia), translocation analysis, qualitative, and quantitative, if performed ewsr1/atf1 (t(12;22)) (eg, clear cell sarcoma), translocation analysis, qualitative, and quantitative, if performed ewsr1/erg (t(21;22)) (eg, ewing sarcoma/peripheral neuroectodermal tumor), translocation analysis, qualitative, and	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	quantitative, if performed ewsr1/fli1 (t(11;22)) (eg, ewing sarcoma/peripheral neuroectodermal tumor), translocation analysis, qualitative, and quantitative, if performed ewsr1/wt1 (t(11;22)) (eg, desmoplastic small round cell tumor), translocation analysis, qualitative, and quantitative, if performed f11 (coagulation factor xi) (eg, coagulation disorder), common variants (eg, e117x [type ii], f283l [type iii], ivs14del14, and ivs14+1g>a [type i]) fgfr3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), common variants (eg, 1138g>a, 1138g>c, 1620c>a, 1620c>g) fip1l1/pdgfra (del[4q12]) (eg, imatinib-sensitive chronic eosinophilic leukemia), qualitative, and quantitative, if performed flg (filaggrin) (eg, ichthyosis vulgaris), common variants (eg, r501x, 2282del4, r2447x, s3247x, 3702delg) foxo1/pax3 (t(2;13)) (eg, alveolar rhabdomyosarcoma), translocation analysis, qualitative, and quantitative, if performed foxo1/pax7 (t(1;13)) (eg, alveolar rhabdomyosarcoma), translocation analysis, qualitative, and quantitative, if performed fus/ddit3 (t(12;16)) (eg, myxoid liposarcoma), translocation analysis, qualitative, and quantitative, if performed galc (galactosylceramidase) (eg, krabbe disease), common variants (eg, c.857g>a, 30-kb deletion) galt (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), common variants (eg, q188r, s135l, k285n, t138m, l195p, y209c, ivs2-2a>g, p171s, del5kb, n314d, l218l/n314d) h19 (imprinted maternally expressed transcript [non-protein coding]) (eg, beckwith-wiedemann syndrome), methylation analysis igh@/bcl2 (t(14;18)) (eg, follicular lymphoma), translocation analysis; single breakpoint (eg, major breakpoint region [mbr] or minor cluster region [mcr]), qualitative or quantitative (when both mbr and mcr breakpoints are performed, use 81278) kcnq1ot1 (kcnq1 overlapping transcript 1 [non-protein coding]) (eg, beckwith-wiedemann syndrome), methylation analysis linc00518 (long intergenic non-protein coding rna 518) (eg, melanoma), expression							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	analysis lrrk2 (leucine-rich repeat kinase 2) (eg, parkinson disease), common variants (eg, r1441g, g2019s, i2020t) med12 (mediator complex subunit 12) (eg, fg syndrome type 1, lujan syndrome), common variants (eg, r961w, n1007s) meg3/dlk1 (maternally expressed 3 [non-protein coding]/delta-like 1 homolog [drosophila]) (eg, intrauterine growth retardation), methylation analysis mll/aff1 (t(4;11)) (eg, acute lymphoblastic leukemia), translocation analysis, qualitative, and quantitative, if performed mll/mllt3 (t(9;11)) (eg, acute myeloid leukemia), translocation analysis, qualitative, and quantitative, if performed mt-atp6 (mitochondrially encoded atp synthase 6) (eg, neuropathy with ataxia and retinitis pigmentosa [narp], leigh syndrome), common variants (eg, m.8993t>g, m.8993t>c) mt-nd4, mt-nd6 (mitochondrially encoded nadh dehydrogenase 4, mitochondrially encoded nadh dehydrogenase 6) (eg, leber hereditary optic neuropathy [lhon]), common variants (eg, m.11778g>a, m.3460g>a, m.14484t>c) mt-nd5 (mitochondrially encoded trna leucine 1 [uua/g], mitochondrially encoded nadh dehydrogenase 5) (eg, mitochondrial encephalopathy with lactic acidosis and stroke-like episodes [melas]), common variants (eg, m.3243a>g, m.3271t>c, m.3252a>g, m.13513g>a) mt-rnr1 (mitochondrially encoded 12s rna) (eg, nonsyndromic hearing loss), common variants (eg, m.1555a>g, m.1494c>t) mt-tk (mitochondrially encoded trna lysine) (eg, myoclonic epilepsy with ragged-red fibers [merrf]), common variants (eg, m.8344a>g, m.8356t>c) mt-tl1 (mitochondrially encoded trna leucine 1 [uua/g]) (eg, diabetes and hearing loss), common variants (eg, m.3243a>g, m.14709 t>c) mt-tl1 mt-ts1, mt-rnr1 (mitochondrially encoded trna serine 1 [ucn], mitochondrially encoded 12s rna) (eg, nonsyndromic sensorineural deafness [including aminoglycoside-induced nonsyndromic deafness]), common variants (eg, m.7445a>g, m.1555a>g) mutyh (muty homolog [e. coli]) (eg, myh-associated polyposis), common variants (eg,							

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	y165c, g382d) nod2 (nucleotide-binding oligomerization domain containing 2) (eg, crohn's disease, blau syndrome), common variants (eg, snp 8, snp 12, snp 13) npm1/alk (t(2;5)) (eg, anaplastic large cell lymphoma), translocation analysis pax8/pparg (t(2;3) (q13;p25)) (eg, follicular thyroid carcinoma), translocation analysis prame (preferentially expressed antigen in melanoma) (eg, melanoma), expression analysis prss1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), common variants (eg, n29i, a16v, r122h) pygm (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type v, mcardle disease), common variants (eg, r50x, g205s) runx1/runx1t1 (t(8;21)) (eg, acute myeloid leukemia) translocation analysis, qualitative, and quantitative, if performed ss18/ssx1 (t(x;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed ss18/ssx2 (t(x;18)) (eg, synovial sarcoma), translocation analysis, qualitative, and quantitative, if performed vwf (von willebrand factor) (eg, von willebrand disease type 2n), common variants (eg, t791m, r816w, r854q)							

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81402	Molecular pathology procedure, level 3 (eg, >10 snps, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and t-cell receptor gene rearrangements, duplication/deletion variants of 1 exon, loss of heterozygosity [loh], uniparental disomy [upd]) chromosome 1p-/19q- (eg, glial tumors), deletion analysis chromosome 18q- (eg, d18s55, d18s58, d18s61, d18s64, and d18s69) (eg, colon cancer), allelic imbalance assessment (ie, loss of heterozygosity) col1a1/pdgfb (t(17;22)) (eg, dermatofibrosarcoma protuberans), translocation analysis, multiple breakpoints, qualitative, and quantitative, if performed cyp21a2 (cytochrome p450, family 21, subfamily a, polypeptide 2) (eg, congenital adrenal hyperplasia, 21-hydroxylase deficiency), common variants (eg, ivs2-13g, p30l, i172n, exon 6 mutation cluster [i235n, v236e, m238k], v281l, l307ffsx6, q318x, r356w, p453s, g110vfsx21, 30-kb deletion variant) esr1/pgr (receptor 1/progesterone receptor) ratio (eg, breast cancer) mefv (mediterranean fever) (eg, familial mediterranean fever), common variants (eg, e148q, p369s, f479l, m680i, i692del, m694v, m694i, k695r, v726a, a744s, r761h) trd@ (t cell antigen receptor, delta) (eg, leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population uniparental disomy (upd) (eg, russell-silver syndrome, prader-willi/angelman syndrome), short tandem repeat (str) analysis	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81403	Molecular pathology procedure, level 4 (eg, analysis of single exon by dna sequence analysis, analysis of >10 amplicons using multiplex pcr in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons) ang (angiogenin, ribonuclease, rnase a family, 5) (eg, amyotrophic lateral sclerosis), full gene sequence arx (aristaless-related homeobox) (eg, x-linked lissencephaly with ambiguous genitalia, x-linked mental retardation), duplication/deletion analysis cel (carboxyl ester lipase [bile salt-stimulated lipase]) (eg, maturity-onset diabetes of the young [mody]), targeted sequence analysis of exon 11 (eg, c.1785delc, c.1686delt) ctnnb1 (catenin [cadherin-associated protein], beta 1, 88kda) (eg, desmoid tumors), targeted sequence analysis (eg, exon 3) daz/sry (deleted in azoospermia and sex determining region y) (eg, male infertility), common deletions (eg, azfa, azfb, azfc, azfd) dnmt3a (dna [cytosine-5-]-methyltransferase 3 alpha) (eg, acute myeloid leukemia), targeted sequence analysis (eg, exon 23) epcam (epithelial cell adhesion molecule) (eg, lynch syndrome), duplication/deletion analysis f8 (coagulation factor viii) (eg, hemophilia a), inversion analysis, intron 1 and intron 22a f12 (coagulation factor xii [hageman factor]) (eg, angioedema, hereditary, type iii; factor xii deficiency), targeted sequence analysis of exon 9 fgfr3 (fibroblast growth factor receptor 3) (eg, isolated craniosynostosis), targeted sequence analysis (eg, exon 7) (for targeted sequence analysis of multiple fgfr3 exons, use 81404) gjb1 (gap junction protein, beta 1) (eg, charcot-marie-tooth x-linked), full gene sequence gnaq (guanine nucleotide-binding protein g[q] subunit alpha) (eg, uveal melanoma), common variants (eg, r183, q209) human erythrocyte antigen gene analyses (eg, slc14a1 [kidd blood group], bcam [lutheran blood group], icam4 [landsteiner-wiener blood group], slc4a1 [diego blood group], aqp1 [colton blood group], ermap [scianna blood group], rhce [rh blood group, ccee antigens], kel [kell blood group], darc [duffy blood	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

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	group], gypa, gypb, gype [mns blood group], art4 [dombrock blood group]) (eg, sickle-cell disease, thalassemia, hemolytic transfusion reactions, hemolytic disease of the fetus or newborn), common variants hras (v-ha-ras harvey rat sarcoma viral oncogene homolog) (eg, costello syndrome), exon 2 sequence kcnc3 (potassium voltage-gated channel, shaw-related subfamily, member 3) (eg, spinocerebellar ataxia), targeted sequence analysis (eg, exon 2) kcnj2 (potassium inwardly-rectifying channel, subfamily j, member 2) (eg, andersen-tawil syndrome), full gene sequence kcnj11 (potassium inwardly-rectifying channel, subfamily j, member 11) (eg, familial hyperinsulinism), full gene sequence killer cell immunoglobulin-like receptor (kir) gene family (eg, hematopoietic stem cell transplantation), genotyping of kir family genes known familial variant not otherwise specified, for gene listed in tier 1 or tier 2, or identified during a genomic sequencing procedure, dna sequence analysis, each variant exon (for a known familial variant that is considered a common variant, use specific common variant tier 1 or tier 2 code) mc4r (melanocortin 4 receptor) (eg, obesity), full gene sequence mica (mhc class i polypeptide-related sequence a) (eg, solid organ transplantation), common variants (eg, *001, *002) mt-rnr1 (mitochondrially encoded 12s rna) (eg, nonsyndromic hearing loss), full gene sequence mt-ts1 (mitochondrially encoded trna serine 1) (eg, nonsyndromic hearing loss), full gene sequence ndp (norrie disease [pseudoglioma]) (eg, norrie disease), duplication/deletion analysis nhlrc1 (nhl repeat containing 1) (eg, progressive myoclonus epilepsy), full gene sequence phox2b (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome), duplication/deletion analysis pln (phospholamban) (eg, dilated cardiomyopathy, hypertrophic cardiomyopathy), full gene sequence rhd (rh blood group, d antigen) (eg, hemolytic disease of the fetus and newborn, rh maternal/fetal compatibility), deletion analysis							

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	(eg, exons 4, 5, and 7, pseudogene) rhd (rh blood group, d antigen) (eg, hemolytic disease of the fetus and newborn, rh maternal/fetal compatibility), deletion analysis (eg, exons 4, 5, and 7, pseudogene), performed on cell-free fetal dna in maternal blood (for human erythrocyte gene analysis of rhd, use a separate unit of 81403) sh2d1a (sh2 domain containing 1a) (eg, x-linked lymphoproliferative syndrome), duplication/deletion analysis twist1 (twist homolog 1 [drosophila]) (eg, saethre-chotzen syndrome), duplication/deletion analysis uba1 (ubiquitin-like modifier activating enzyme 1) (eg, spinal muscular atrophy, x-linked), targeted sequence analysis (eg, exon 15) vhl (von hippel-lindau tumor suppressor) (eg, von hippel-lindau familial cancer syndrome), deletion/duplication analysis vwf (von willebrand factor) (eg, von willebrand disease types 2a, 2b, 2m), targeted sequence analysis (eg, exon 28)							

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81404	Molecular pathology procedure, level 5 (eg, analysis of 2-5 exons by dna sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by southern blot analysis) acads (acyl-coa dehydrogenase, c-2 to c-3 short chain) (eg, short chain acyl-coa dehydrogenase deficiency), targeted sequence analysis (eg, exons 5 and 6) aqp2 (aquaporin 2 [collecting duct]) (eg, nephrogenic diabetes insipidus), full gene sequence arx (aristaless related homeobox) (eg, x-linked lissencephaly with ambiguous genitalia, x-linked mental retardation), full gene sequence avpr2 (arginine vasopressin receptor 2) (eg, nephrogenic diabetes insipidus), full gene sequence bbs10 (bardet-biedl syndrome 10) (eg, bardet-biedl syndrome), full gene sequence btd (biotinidase) (eg, biotinidase deficiency), full gene sequence c10orf2 (chromosome 10 open reading frame 2) (eg, mitochondrial dna depletion syndrome), full gene sequence cav3 (caveolin 3) (eg, cav3-related distal myopathy, limb-girdle muscular dystrophy type 1c), full gene sequence cd40lg (cd40 ligand) (eg, x-linked hyper igm syndrome), full gene sequence cdkn2a (cyclin-dependent kinase inhibitor 2a) (eg, cdkn2a-related cutaneous malignant melanoma, familial atypical mole-malignant melanoma syndrome), full gene sequence clrn1 (clarin 1) (eg, usher syndrome, type 3), full gene sequence cox6b1 (cytochrome c oxidase subunit vib polypeptide 1) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence cpt2 (carnitine palmitoyltransferase 2) (eg, carnitine palmitoyltransferase ii deficiency), full gene sequence crx (cone-rod homeobox) (eg, cone-rod dystrophy 2, leber congenital amaurosis), full gene sequence cyp1b1 (cytochrome p450, family 1, subfamily b, polypeptide 1) (eg, primary congenital glaucoma), full gene sequence egr2 (early growth response 2) (eg, charcot-marie-tooth), full gene sequence emd (emerin) (eg, emery-dreifuss	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	muscular dystrophy), duplication/deletion analysis epm2a (epilepsy, progressive myoclonus type 2a, lafora disease [laforin]) (eg, progressive myoclonus epilepsy), full gene sequence fgf23 (fibroblast growth factor 23) (eg, hypophosphatemic rickets), full gene sequence fgfr2 (fibroblast growth factor receptor 2) (eg, craniosynostosis, apert syndrome, crouzon syndrome), targeted sequence analysis (eg, exons 8, 10) fgfr3 (fibroblast growth factor receptor 3) (eg, achondroplasia, hypochondroplasia), targeted sequence analysis (eg, exons 8, 11, 12, 13) fhl1 (four and a half lim domains 1) (eg, emery-dreifuss muscular dystrophy), full gene sequence fkrp (fukutin related protein) (eg, congenital muscular dystrophy type 1c [mdc1c], limb-girdle muscular dystrophy [lgmd] type 2i), full gene sequence foxg1 (forkhead box g1) (eg, rett syndrome), full gene sequence fshmd1a (facioscapulohumeral muscular dystrophy 1a) (eg, facioscapulohumeral muscular dystrophy), evaluation to detect abnormal (eg, deleted) alleles fshmd1a (facioscapulohumeral muscular dystrophy 1a) (eg, facioscapulohumeral muscular dystrophy), characterization of haplotype(s) (ie, chromosome 4a and 4b haplotypes) gh1 (growth hormone 1) (eg, growth hormone deficiency), full gene sequence gp1bb (glycoprotein ib [platelet], beta polypeptide) (eg, bernard-soulier syndrome type b), full gene sequence (for common deletion variants of alpha globin 1 and alpha globin 2 genes, use 81257) hnf1b (hnf1 homeobox b) (eg, maturity-onset diabetes of the young [mody]), duplication/deletion analysis hras (v-ha-ras harvey rat sarcoma viral oncogene homolog) (eg, costello syndrome), full gene sequence hsd3b2 (hydroxy-delta-5-steroid dehydrogenase, 3 beta- and steroid delta-isomerase 2) (eg, 3-beta-hydroxysteroid dehydrogenase type ii deficiency), full gene sequence hsd11b2 (hydroxysteroid [11-beta] dehydrogenase 2) (eg, mineralocorticoid excess syndrome), full gene sequence hspb1 (heat shock 27kda protein 1) (eg, charcot-marie-tooth disease),							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	full gene sequence ins (insulin) (eg, diabetes mellitus), full gene sequence kcnj1 (potassium inwardly-rectifying channel, subfamily j, member 1) (eg, bartter syndrome), full gene sequence kcnj10 (potassium inwardly-rectifying channel, subfamily j, member 10) (eg, sesame syndrome, east syndrome, sensorineural hearing loss), full gene sequence litaf (lipopolysaccharide-induced tnf factor) (eg, charcot-marie-tooth), full gene sequence mefv (mediterranean fever) (eg, familial mediterranean fever), full gene sequence men1 (multiple endocrine neoplasia i) (eg, multiple endocrine neoplasia type 1, wermer syndrome), duplication/deletion analysis mmachc (methylmalonic aciduria [cobalamin deficiency] cblc type, with homocystinuria) (eg, methylmalonic acidemia and homocystinuria), full gene sequence mpv17 (mpv17 mitochondrial inner membrane protein) (eg, mitochondrial dna depletion syndrome), duplication/deletion analysis ndp (norrie disease [pseudoglioma]) (eg, norrie disease), full gene sequence ndufa1 (nadh dehydrogenase [ubiquinone] 1 alpha subcomplex, 1, 7.5kda) (eg, leigh syndrome, mitochondrial complex i deficiency), full gene sequence ndufaf2 (nadh dehydrogenase [ubiquinone] 1 alpha subcomplex, assembly factor 2) (eg, leigh syndrome, mitochondrial complex i deficiency), full gene sequence ndufs4 (nadh dehydrogenase [ubiquinone] fe-s protein 4, 18kda [nadh-coenzyme q reductase]) (eg, leigh syndrome, mitochondrial complex i deficiency), full gene sequence nipa1 (non-imprinted in prader-willi/angelman syndrome 1) (eg, spastic paraplegia), full gene sequence nlgn4x (neuroligin 4, x-linked) (eg, autism spectrum disorders), duplication/deletion analysis npc2 (niemann-pick disease, type c2 [epididymal secretory protein e1]) (eg, niemann-pick disease type c2), full gene sequence nr0b1 (nuclear receptor subfamily 0, group b, member 1) (eg, congenital adrenal hypoplasia), full gene sequence pdx1 (pancreatic and duodenal homeobox 1) (eg, maturity-onset diabetes of the							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	young [mody]), full gene sequence phox2b (paired-like homeobox 2b) (eg, congenital central hypoventilation syndrome), full gene sequence plp1 (proteolipid protein 1) (eg, pelizaeus-merzbacher disease, spastic paraplegia), duplication/deletion analysis pqbp1 (polyglutamine binding protein 1) (eg, renpenning syndrome), duplication/deletion analysis prnp (prion protein) (eg, genetic prion disease), full gene sequence prop1 (prop paired-like homeobox 1) (eg, combined pituitary hormone deficiency), full gene sequence prph2 (peripherin 2 [retinal degeneration, slow]) (eg, retinitis pigmentosa), full gene sequence prss1 (protease, serine, 1 [trypsin 1]) (eg, hereditary pancreatitis), full gene sequence raf1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, leopard syndrome), targeted sequence analysis (eg, exons 7, 12, 14, 17) ret (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2b and familial medullary thyroid carcinoma), common variants (eg, m918t, 2647_2648delinstt, a883f) rho (rhodopsin) (eg, retinitis pigmentosa), full gene sequence rp1 (retinitis pigmentosa 1) (eg, retinitis pigmentosa), full gene sequence scn1b (sodium channel, voltage-gated, type i, beta) (eg, brugada syndrome), full gene sequence sco2 (sco cytochrome oxidase deficient homolog 2 [sco1l]) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence sdhc (succinate dehydrogenase complex, subunit c, integral membrane protein, 15kda) (eg, hereditary paraganglioma-pheochromocytoma syndrome), duplication/deletion analysis sdhd (succinate dehydrogenase complex, subunit d, integral membrane protein) (eg, hereditary paraganglioma), full gene sequence sgcg (sarcoglycan, gamma [35kda dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), duplication/deletion analysis sh2d1a (sh2 domain containing 1a) (eg, x-linked lymphoproliferative syndrome), full gene sequence slc16a2 (solute carrier family 16, member 2							

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	[thyroid hormone transporter]) (eg, specific thyroid hormone cell transporter deficiency, allan-herndon-dudley syndrome), duplication/deletion analysis slc25a20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), duplication/deletion analysis slc25a4 (solute carrier family 25 [mitochondrial carrier; adenine nucleotide translocator], member 4) (eg, progressive external ophthalmoplegia), full gene sequence sod1 (superoxide dismutase 1, soluble) (eg, amyotrophic lateral sclerosis), full gene sequence spink1 (serine peptidase inhibitor, kazal type 1) (eg, hereditary pancreatitis), full gene sequence stk11 (serine/threonine kinase 11) (eg, peutz-jeghers syndrome), duplication/deletion analysis taco1 (translational activator of mitochondrial encoded cytochrome c oxidase i) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence thap1 (thap domain containing, apoptosis associated protein 1) (eg, torsion dystonia), full gene sequence tor1a (torsin family 1, member a [torsin a]) (eg, torsion dystonia), full gene sequence ttpa (tocopherol [alpha] transfer protein) (eg, ataxia), full gene sequence ttr (transthyretin) (eg, familial transthyretin amyloidosis), full gene sequence twist1 (twist homolog 1 [drosophila]) (eg, saethre-chotzen syndrome), full gene sequence tyr (tyrosinase [oculocutaneous albinism ia]) (eg, oculocutaneous albinism ia), full gene sequence ugt1a1 (udp glucuronosyltransferase 1 family, polypeptide a1) (eg, hereditary unconjugated hyperbilirubinemia [crigler-najjar syndrome]) full gene sequence ush1g (usher syndrome 1g [autosomal recessive]) (eg, usher syndrome, type 1), full gene sequence vhl (von hippel-lindau tumor suppressor) (eg, von hippel-lindau familial cancer syndrome), full gene sequence vwf (von willebrand factor) (eg, von willebrand disease type 1c), targeted sequence analysis (eg, exons 26, 27, 37) zeb2 (zinc finger e-box binding homeobox 2) (eg, mowat-wilson syndrome), duplication/deletion							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	analysis znf41 (zinc finger protein 41) (eg, x-linked mental retardation 89), full gene sequence							

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81405	Molecular pathology procedure, level 6 (eg, analysis of 6-10 exons by dna sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons, regionally targeted cytogenomic array analysis) abcd1 (atp-binding cassette, sub-family d [ald], member 1) (eg, adrenoleukodystrophy), full gene sequence acads (acyl-coa dehydrogenase, c-2 to c-3 short chain) (eg, short chain acyl-coa dehydrogenase deficiency), full gene sequence acta2 (actin, alpha 2, smooth muscle, aorta) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence actc1 (actin, alpha, cardiac muscle 1)(eg, familial hypertrophic cardiomyopathy), full gene sequence ankrd1 (ankyrin repeat domain 1) (eg, dilated cardiomyopathy), full gene sequence aptx (aprataxin) (eg, ataxia with oculomotor apraxia 1), full gene sequence arsa (arylsulfatase a) (eg, arylsulfatase a deficiency), full gene sequence bckdha (branched chain keto acid dehydrogenase e1, alpha polypeptide) (eg, maple syrup urine disease, type 1a), full gene sequence bcs1l (bcs1-like [s. cerevisiae]) (eg, leigh syndrome, mitochondrial complex iii deficiency, gracile syndrome), full gene sequence bmpr2 (bone morphogenetic protein receptor, type ii [serine/threonine kinase]) (eg, heritable pulmonary arterial hypertension), duplication/deletion analysis casq2 (calsequestrin 2 [cardiac muscle]) (eg, catecholaminergic polymorphic ventricular tachycardia), full gene sequence casr (calcium-sensing receptor) (eg, hypocalcemia), full gene sequence cdkl5 (cyclin-dependent kinase-like 5) (eg, early infantile epileptic encephalopathy), duplication/deletion analysis chrna4 (cholinergic receptor, nicotinic, alpha 4) (eg, nocturnal frontal lobe epilepsy), full gene sequence chrnb2 (cholinergic receptor, nicotinic, beta 2 [neuronal])(eg, nocturnal frontal lobe epilepsy), full gene sequence cox10 (cox10 homolog, cytochrome c oxidase assembly protein) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence cox15 (cox15	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	homolog, cytochrome c oxidase assembly protein) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence cpox (coproporphyrinogen oxidase) (eg, hereditary coproporphyria), full gene sequence ctrc (chymotrypsin c) (eg, hereditary pancreatitis), full gene sequence cyp11b1 (cytochrome p450, family 11, subfamily b, polypeptide 1) (eg, congenital adrenal hyperplasia), full gene sequence cyp17a1 (cytochrome p450, family 17, subfamily a, polypeptide 1) (eg, congenital adrenal hyperplasia), full gene sequence cyp21a2 (cytochrome p450, family 21, subfamily a, polypeptide2) (eg, steroid 21-hydroxylase isoform, congenital adrenal hyperplasia), full gene sequence cytogenomic constitutional targeted microarray analysis of chromosome 22q13 by interrogation of genomic regions for copy number and single nucleotide polymorphism (snp) variants for chromosomal abnormalities (when performing cytogenomic [genome-wide] analysis for constitutional chromosomal abnormalities, see 81228, 81229, 81349) (do not report analyte-specific molecular pathology procedures separately when the specific analytes are included as part of the microarray analysis of chromosome 22q13) (do not report 88271 when performing cytogenomic microarray analysis) dbt (dihydrolipoamide branched chain transacylase e2) (eg, maple syrup urine disease, type 2), duplication/deletion analysis dcx (doublecortin) (eg, x-linked lissencephaly), full gene sequence des (desmin) (eg, myofibrillar myopathy), full gene sequence dfnb59 (deafness, autosomal recessive 59)(eg, autosomal recessive nonsyndromic hearing impairment), full gene sequence dguok (deoxyguanosine kinase) (eg, hepatocerebral mitochondrial dna depletion syndrome), full gene sequence dhcr7 (7-dehydrocholesterol reductase) (eg, smith-lemli-opitz syndrome), full gene sequence eif2b2 (eukaryotic translation initiation factor 2b, subunit 2 beta, 39kda)(eg, leukoencephalopathy with vanishing white matter),							

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	full gene sequence emd (emerin) (eg, emery-dreifuss muscular dystrophy), full gene sequence eng (endoglin) (eg, hereditary hemorrhagic telangiectasia, type 1), duplication/deletion analysis eya1 (eyes absent homolog 1 [drosophila]) (eg, branchio-oto-renal [bor] spectrum disorders), duplication/deletion analysis fgfr1 (fibroblast growth factor receptor 1) (eg, kallmann syndrome 2), full gene sequence fh (fumarate hydratase) (eg, fumarate hydratase deficiency, hereditary leiomyomatosis with renal cell cancer), full gene sequence fktn (fukutin) (eg, limb-girdle muscular dystrophy [lgmd] type 2m or 2l), full gene sequence ftsj1 (ftsj rna methyltransferase homolog 1 [e. coli])(eg, x-linked mental retardation 9), duplication/deletion analysis gabrg2 (gamma-aminobutyric acid [gaba] a receptor, gamma 2) (eg, generalized epilepsy with febrile seizures), full gene sequence gch1 (gtp cyclohydrolase 1) (eg, autosomal dominant dopa-responsive dystonia), full gene sequence gdap1 (ganglioside-induced differentiation-associated protein 1) (eg, charcot-marie-tooth disease), full gene sequence gfap (glial fibrillary acidic protein) (eg, alexander disease), full gene sequence ghr (growth hormone receptor) (eg, laron syndrome), full gene sequence ghrhr (growth hormone releasing hormone receptor) (eg, growth hormone deficiency), full gene sequence gla (galactosidase, alpha) (eg, fabry disease), full gene sequence hnf1a (hnf1 homeobox a) (eg, maturity-onset diabetes of the young [mody]), full gene sequence hnf1b (hnf1 homeobox b) (eg, maturity-onset diabetes of the young [mody]), full gene sequence htra1 (htra serine peptidase 1) (eg, macular degeneration), full gene sequence ids (iduronate 2-sulfatase) (eg, mucopolysacchridosis, type ii), full gene sequence il2rg (interleukin 2 receptor, gamma)(eg, x-linked severe combined immunodeficiency), full gene sequence ispd (isoprenoid synthase domain containing) (eg, muscle-eye-brain disease, walker-warburg syndrome), full gene sequence kras (kirsten rat								

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	sarcoma viral oncogene homolog) (eg, noonan syndrome), full gene sequence lamp2 (lysosomal-associated membrane protein 2) (eg, danon disease), full gene sequence ldlr (low density lipoprotein receptor) (eg, familial hypercholesterolemia), duplication/deletion analysis men1 (multiple endocrine neoplasia i) (eg, multiple endocrine neoplasia type 1, wermer syndrome), full gene sequence mmaa (methylmalonic aciduria [cobalamine deficiency] type a) (eg, mmaa-related methylmalonic acidemia), full gene sequence mmab (methylmalonic aciduria [cobalamine deficiency] type b) (eg, mmaa-related methylmalonic acidemia), full gene sequence mpi (mannose phosphate isomerase) (eg, congenital disorder of glycosylation 1b), full gene sequence mpv17 (mpv17 mitochondrial inner membrane protein)(eg, mitochondrial dna depletion syndrome), full gene sequence mpz (myelin protein zero) (eg, charcot-marie-tooth), full gene sequence mtm1 (myotubularin 1) (eg, x-linked centronuclear myopathy), duplication/deletion analysis myl2 (myosin, light chain 2, regulatory, cardiac, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence myl3 (myosin, light chain 3, alkali, ventricular, skeletal, slow) (eg, familial hypertrophic cardiomyopathy), full gene sequence myot (myotilin) (eg, limb-girdle muscular dystrophy), full gene sequence ndufs7 (nadh dehydrogenase [ubiquinone] fe-s protein 7, 20kda [nadh-coenzyme q reductase]) (eg, leigh syndrome, mitochondrial complex i deficiency), full gene sequence ndufs8 (nadh dehydrogenase [ubiquinone] fe-s protein 8, 23kda [nadh-coenzyme q reductase]) (eg, leigh syndrome, mitochondrial complex i deficiency), full gene sequence ndufv1 (nadh dehydrogenase [ubiquinone] flavoprotein 1, 51kda) (eg, leigh syndrome, mitochondrial complex i deficiency), full gene sequence nefl (neurofilament, light polypeptide) (eg, charcot-marie-tooth), full gene sequence nf2 (neurofibromin 2 [merlin]) (eg, neurofibromatosis,							

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	type 2), duplication/deletion analysis nlgn3 (neuroligin 3) (eg, autism spectrum disorders), full gene sequence nlgn4x (neuroligin 4, x-linked) (eg, autism spectrum disorders), full gene sequence nphp1 (nephronophthisis 1 [juvenile]) (eg, joubert syndrome), deletion analysis, and duplication analysis, if performed nphs2 (nephrosis 2, idiopathic, steroid-resistant [podocin]) (eg, steroid-resistant nephrotic syndrome), full gene sequence nsd1 (nuclear receptor binding set domain protein 1) (eg, sotos syndrome), duplication/deletion analysis otc (ornithine carbamoyltransferase) (eg, ornithine transcarbamylase deficiency), full gene sequence pafah1b1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kda]) (eg, lissencephaly, miller-dieker syndrome), duplication/deletion analysis park2 (parkinson protein 2, e3 ubiquitin protein ligase [parkin]) (eg, parkinson disease), duplication/deletion analysis pcca (propionyl coa carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), duplication/deletion analysis pcdh19 (protocadherin 19) (eg, epileptic encephalopathy), full gene sequence pdha1 (pyruvate dehydrogenase [lipoamide] alpha 1)(eg, lactic acidosis), duplication/deletion analysis pdhb (pyruvate dehydrogenase [lipoamide] beta) (eg, lactic acidosis), full gene sequence pink1 (pten induced putative kinase 1) (eg, parkinson disease), full gene sequence pklr (pyruvate kinase, liver and rbc) (eg, pyruvate kinase deficiency), full gene sequence plp1 (proteolipid protein 1) (eg, pelizaeus-merzbacher disease, spastic paraplegia), full gene sequence pou1f1 (pou class 1 homeobox 1) (eg, combined pituitary hormone deficiency), full gene sequence prx (periaxin) (eg, charcot-marie-tooth disease), full gene sequence pqbp1 (polyglutamine binding protein 1) (eg, renpenning syndrome), full gene sequence psen1 (presenilin 1) (eg, alzheimer disease), full gene sequence rab7a (rab7a, member ras oncogene family) (eg, charcot-marie-tooth disease), full gene sequence rai1 (retinoic								

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	acid induced 1) (eg, smith-magenis syndrome), full gene sequence reep1 (receptor accessory protein 1) (eg, spastic paraplegia), full gene sequence ret (ret proto-oncogene) (eg, multiple endocrine neoplasia, type 2a and familial medullary thyroid carcinoma), targeted sequence analysis (eg, exons 10, 11, 13-16) rps19 (ribosomal protein s19) (eg, diamond-blackfan anemia), full gene sequence rrm2b (ribonucleotide reductase m2 b [tp53 inducible]) (eg, mitochondrial dna depletion), full gene sequence sco1 (sco cytochrome oxidase deficient homolog 1) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence sdhb (succinate dehydrogenase complex, subunit b, iron sulfur) (eg, hereditary paraganglioma), full gene sequence sdhc (succinate dehydrogenase complex, subunit c, integral membrane protein, 15kda) (eg, hereditary paraganglioma-pheochromocytoma syndrome), full gene sequence sgca (sarcoglycan, alpha [50kda dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence sgcb (sarcoglycan, beta [43kda dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence sgcd (sarcoglycan, delta [35kda dystrophin-associated glycoprotein]) (eg, limb-girdle muscular dystrophy), full gene sequence sgce (sarcoglycan, epsilon) (eg, myoclonic dystonia), duplication/deletion analysis sgcg (sarcoglycan, gamma [35kda dystrophin-associated glycoprotein])(eg, limb-girdle muscular dystrophy), full gene sequence shoc2 (soc-2 suppressor of clear homolog) (eg, noonan-like syndrome with loose anagen hair), full gene sequence shox (short stature homeobox)(eg, langer mesomelic dysplasia), full gene sequence sil1 (sil1 homolog, endoplasmic reticulum chaperone [s. cerevisiae]) (eg, ataxia), full gene sequence slc2a1 (solute carrier family 2 [facilitated glucose transporter], member 1) (eg, glucose transporter type 1 [glut 1] deficiency syndrome), full gene sequence slc16a2 (solute carrier family 16, member 2 [thyroid hormone transporter]) (eg,							

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	specific thyroid hormone cell transporter deficiency, allan-herndon-dudley syndrome), full gene sequence slc22a5 (solute carrier family 22 [organic cation/carnitine transporter], member 5) (eg, systemic primary carnitine deficiency), full gene sequence slc25a20 (solute carrier family 25 [carnitine/acylcarnitine translocase], member 20) (eg, carnitine-acylcarnitine translocase deficiency), full gene sequence smad4 (smad family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), duplication/deletion analysis spast (spastin) (eg, spastic paraplegia), duplication/deletion analysis spg7 (spastic paraplegia 7 [pure and complicated autosomal recessive])(eg, spastic paraplegia), duplication/deletion analysis spred1 (sprouty-related, evh1 domain containing 1) (eg, legius syndrome), full gene sequence stat3 (signal transducer and activator of transcription 3 [acute-phase response factor]) (eg, autosomal dominant hyper-ige syndrome), targeted sequence analysis (eg, exons 12, 13, 14, 16, 17, 20, 21) stk11 (serine/threonine kinase 11) (eg, peutz-jeghers syndrome), full gene sequence surf1 (surfeit 1) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence tardbp (tar dna binding protein) (eg, amyotrophic lateral sclerosis), full gene sequence tbx5 (t-box 5) (eg, holt-oram syndrome), full gene sequence tcf4 (transcription factor 4) (eg, pitt-hopkins syndrome), duplication/deletion analysis tgfbr1 (transforming growth factor, beta receptor 1) (eg, marfan syndrome), full gene sequence tgfbr2 (transforming growth factor, beta receptor 2) (eg, marfan syndrome), full gene sequence thrb (thyroid hormone receptor, beta) (eg, thyroid hormone resistance, thyroid hormone beta receptor deficiency), full gene sequence or targeted sequence analysis of >5 exons tk2 (thymidine kinase 2, mitochondrial) (eg, mitochondrial dna depletion syndrome), full gene sequence tnnc1 (troponin c type 1 [slow]) (eg, hypertrophic cardiomyopathy or dilated							

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	cardiomyopathy), full gene sequence tnni3 (troponin i, type 3 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence tpm1 (tropomyosin 1 [alpha]) (eg, familial hypertrophic cardiomyopathy), full gene sequence tsc1 (tuberous sclerosis 1) (eg, tuberous sclerosis), duplication/deletion analysis tymp (thymidine phosphorylase) (eg, mitochondrial dna depletion syndrome), full gene sequence vwf (von willebrand factor) (eg, von willebrand disease type 2n), targeted sequence analysis (eg, exons 18-20, 23-25) wt1 (wilms tumor 1) (eg, denys-drash syndrome, familial wilms tumor), full gene sequence zeb2 (zinc finger e-box binding homeobox 2)(eg, mowat-wilson syndrome), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81406	Molecular pathology procedure, level 7 (eg, analysis of 11-25 exons by dna sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons) acadvl (acyl-coa dehydrogenase, very long chain) (eg, very long chain acyl-coenzyme a dehydrogenase deficiency), full gene sequence actn4 (actinin, alpha 4) (eg, focal segmental glomerulosclerosis), full gene sequence afg3l2 (afg3 atpase family gene 3-like 2 [s. cerevisiae]) (eg, spinocerebellar ataxia), full gene sequence aire (autoimmune regulator) (eg, autoimmune polyendocrinopathy syndrome type 1), full gene sequence aldh7a1 (aldehyde dehydrogenase 7 family, member a1) (eg, pyridoxine-dependent epilepsy), full gene sequence ano5 (anoctamin 5) (eg, limb-girdle muscular dystrophy), full gene sequence anos1 (anosmin-1) (eg, kallmann syndrome 1), full gene sequence app (amyloid beta [a4] precursor protein) (eg, alzheimer disease), full gene sequence ass1 (argininosuccinate synthase 1) (eg, citrullinemia type i), full gene sequence atl1 (atlastin gtpase 1) (eg, spastic paraplegia), full gene sequence atp1a2 (atpase, na+/k+ transporting, alpha 2 polypeptide) (eg, familial hemiplegic migraine), full gene sequence atp7b (atpase, cu++ transporting, beta polypeptide) (eg, wilson disease), full gene sequence bbs1 (bardet-biedl syndrome 1) (eg, bardet-biedl syndrome), full gene sequence bbs2 (bardet-biedl syndrome 2) (eg, bardet-biedl syndrome), full gene sequence bckdhb (branched-chain keto acid dehydrogenase e1, beta polypeptide) (eg, maple syrup urine disease, type 1b), full gene sequence best1 (bestrophin 1) (eg, vitelliform macular dystrophy), full gene sequence bmpr2 (bone morphogenetic protein receptor, type ii [serine/threonine kinase]) (eg, heritable pulmonary arterial hypertension), full gene sequence braf (b-raf proto-oncogene, serine/threonine kinase) (eg, noonan syndrome), full gene sequence bscl2 (berardinelli-seip congenital lipodystrophy 2 [seipin]) (eg, berardinelli-seip congenital lipodystrophy), full	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	gene sequence btk (bruton agammaglobulinemia tyrosine kinase) (eg, x-linked agammaglobulinemia), full gene sequence cacnb2 (calcium channel, voltage-dependent, beta 2 subunit) (eg, brugada syndrome), full gene sequence capn3 (calpain 3) (eg, limb-girdle muscular dystrophy [lgmd] type 2a, calpainopathy), full gene sequence cbs (cystathionine-beta-synthase) (eg, homocystinuria, cystathionine beta-synthase deficiency), full gene sequence cdh1 (cadherin 1, type 1, e-cadherin [epithelial]) (eg, hereditary diffuse gastric cancer), full gene sequence cdkl5 (cyclin-dependent kinase-like 5) (eg, early infantile epileptic encephalopathy), full gene sequence clcn1 (chloride channel 1, skeletal muscle) (eg, myotonia congenita), full gene sequence clcnkb (chloride channel, voltage-sensitive kb) (eg, bartter syndrome 3 and 4b), full gene sequence cntnap2 (contactin-associated protein-like 2) (eg, pitt-hopkins-like syndrome 1), full gene sequence col6a2 (collagen, type vi, alpha 2) (eg, collagen type vi-related disorders), duplication/deletion analysis cpt1a (carnitine palmitoyltransferase 1a [liver]) (eg, carnitine palmitoyltransferase 1a [cpt1a] deficiency), full gene sequence crb1 (crumbs homolog 1 [drosophila]) (eg, leber congenital amaurosis), full gene sequence crebbp (creb binding protein) (eg, rubinstein-taybi syndrome), duplication/deletion analysis dbt (dihydrolipoamide branched chain transacylase e2) (eg, maple syrup urine disease, type 2), full gene sequence dlat (dihydrolipoamide s-acetyltransferase) (eg, pyruvate dehydrogenase e2 deficiency), full gene sequence dld (dihydrolipoamide dehydrogenase) (eg, maple syrup urine disease, type iii), full gene sequence dsc2 (desmocollin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 11), full gene sequence dsg2 (desmoglein 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 10), full gene sequence dsp (desmoplakin) (eg, arrhythmogenic right							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	ventricular dysplasia/cardiomyopathy 8), full gene sequence efhc1 (ef-hand domain [c-terminal] containing 1) (eg, juvenile myoclonic epilepsy), full gene sequence eif2b3 (eukaryotic translation initiation factor 2b, subunit 3 gamma, 58kda) (eg, leukoencephalopathy with vanishing white matter), full gene sequence eif2b4 (eukaryotic translation initiation factor 2b, subunit 4 delta, 67kda) (eg, leukoencephalopathy with vanishing white matter), full gene sequence eif2b5 (eukaryotic translation initiation factor 2b, subunit 5 epsilon, 82kda) (eg, childhood ataxia with central nervous system hypomyelination/vanishing white matter), full gene sequence eng (endoglin) (eg, hereditary hemorrhagic telangiectasia, type 1), full gene sequence eya1 (eyes absent homolog 1 [drosophila]) (eg, branchio-oto-renal [bor] spectrum disorders), full gene sequence f8 (coagulation factor viii) (eg, hemophilia a), duplication/deletion analysis fah (fumarylacetoacetate hydrolase [fumarylacetoacetase]) (eg, tyrosinemia, type 1), full gene sequence fastkd2 (fast kinase domains 2) (eg, mitochondrial respiratory chain complex iv deficiency), full gene sequence fig4 (fig4 homolog, sac1 lipid phosphatase domain containing [s. cerevisiae]) (eg, charcot-marie-tooth disease), full gene sequence ftsj1 (ftsj rna methyltransferase homolog 1 [e. coli]) (eg, x-linked mental retardation 9), full gene sequence fus (fused in sarcoma) (eg, amyotrophic lateral sclerosis), full gene sequence gaa (glucosidase, alpha; acid) (eg, glycogen storage disease type ii [pompe disease]), full gene sequence galc (galactosylceramidase) (eg, krabbe disease), full gene sequence galt (galactose-1-phosphate uridylyltransferase) (eg, galactosemia), full gene sequence gars (glycyl-trna synthetase) (eg, charcot-marie-tooth disease), full gene sequence gcdh (glutaryl-coa dehydrogenase) (eg, glutaricacidemia type 1), full gene sequence gck (glucokinase [hexokinase 4]) (eg, maturity-onset diabetes of the young [mody]), full gene sequence glud1 (glutamate dehydrogenase 1) (eg, familial							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	hyperinsulinism), full gene sequence gne (glucosamine [udp-n-acetyl]-2-epimerase/n-acetylmannosamine kinase) (eg, inclusion body myopathy 2 [ibm2], nonaka myopathy), full gene sequence grn (granulin) (eg, frontotemporal dementia), full gene sequence hadha (hydroxyacyl-coa dehydrogenase/3-ketoacyl-coa thiolase/enoyl-coa hydratase [trifunctional protein] alpha subunit) (eg, long chain acyl-coenzyme a dehydrogenase deficiency), full gene sequence hadhb (hydroxyacyl-coa dehydrogenase/3-ketoacyl-coa thiolase/enoyl-coa hydratase [trifunctional protein], beta subunit) (eg, trifunctional protein deficiency), full gene sequence hexa (hexosaminidase a, alpha polypeptide) (eg, tay-sachs disease), full gene sequence hlcs (hlcs holocarboxylase synthetase) (eg, holocarboxylase synthetase deficiency), full gene sequence hmbs (hydroxymethylbilane synthase) (eg, acute intermittent porphyria), full gene sequence hnf4a (hepatocyte nuclear factor 4, alpha) (eg, maturity-onset diabetes of the young [mody]), full gene sequence idua (iduronidase, alpha-l-) (eg, mucopolysaccharidosis type i), full gene sequence inf2 (inverted formin, fh2 and wh2 domain containing) (eg, focal segmental glomerulosclerosis), full gene sequence ivd (isovaleryl-coa dehydrogenase) (eg, isovaleric acidemia), full gene sequence jag1 (jagged 1) (eg, alagille syndrome), duplication/deletion analysis jup (junction plakoglobin) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 11), full gene sequence kcnh2 (potassium voltage-gated channel, subfamily h [eag-related], member 2) (eg, short qt syndrome, long qt syndrome), full gene sequence kcnq1 (potassium voltage-gated channel, kqt-like subfamily, member 1) (eg, short qt syndrome, long qt syndrome), full gene sequence kcnq2 (potassium voltage-gated channel, kqt-like subfamily, member 2) (eg, epileptic encephalopathy), full gene sequence ldb3 (lim domain binding 3) (eg, familial dilated cardiomyopathy, myofibrillar myopathy), full gene							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sequence ldlr (low density lipoprotein receptor) (eg, familial hypercholesterolemia), full gene sequence lepr (leptin receptor) (eg, obesity with hypogonadism), full gene sequence lhcgr (luteinizing hormone/choriogonadotropin receptor) (eg, precocious male puberty), full gene sequence lmna (lamin a/c) (eg, emery-dreifuss muscular dystrophy [edmd1, 2 and 3] limb-girdle muscular dystrophy [lgmd] type 1b, dilated cardiomyopathy [cmd1a], familial partial lipodystrophy [fpld2]), full gene sequence lrp5 (low density lipoprotein receptor-related protein 5) (eg, osteopetrosis), full gene sequence map2k1 (mitogen-activated protein kinase 1) (eg, cardiofaciocutaneous syndrome), full gene sequence map2k2 (mitogen-activated protein kinase 2) (eg, cardiofaciocutaneous syndrome), full gene sequence mapt (microtubule-associated protein tau) (eg, frontotemporal dementia), full gene sequence mccc1 (methylcrotonoyl-coa carboxylase 1 [alpha]) (eg, 3-methylcrotonyl-coa carboxylase deficiency), full gene sequence mccc2 (methylcrotonoyl-coa carboxylase 2 [beta]) (eg, 3-methylcrotonyl carboxylase deficiency), full gene sequence mfn2 (mitofusin 2) (eg, charcot-marie-tooth disease), full gene sequence mtm1 (myotubularin 1) (eg, x-linked centronuclear myopathy), full gene sequence mut (methylmalonyl coa mutase) (eg, methylmalonic acidemia), full gene sequence mutyh (muty homolog [e. coli]) (eg, myh-associated polyposis), full gene sequence ndufs1 (nadh dehydrogenase [ubiquinone] fe-s protein 1, 75kda [nadh-coenzyme q reductase]) (eg, leigh syndrome, mitochondrial complex i deficiency), full gene sequence nf2 (neurofibromin 2 [merlin]) (eg, neurofibromatosis, type 2), full gene sequence notch3 (notch 3) (eg, cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy [cadasil]), targeted sequence analysis (eg, exons 1-23) npc1 (niemann-pick disease, type c1) (eg, niemann-pick disease), full gene sequence nphp1 (nephronophthisis 1 [juvenile]) (eg, joubert							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	syndrome), full gene sequence nsd1 (nuclear receptor binding set domain protein 1) (eg, sotos syndrome), full gene sequence opa1 (optic atrophy 1) (eg, optic atrophy), duplication/deletion analysis optn (optineurin) (eg, amyotrophic lateral sclerosis), full gene sequence pafah1b1 (platelet-activating factor acetylhydrolase 1b, regulatory subunit 1 [45kda]) (eg, lissencephaly, miller-dieker syndrome), full gene sequence pah (phenylalanine hydroxylase) (eg, phenylketonuria), full gene sequence park2 (parkinson protein 2, e3 ubiquitin protein ligase [parkin]) (eg, parkinson disease), full gene sequence pax2 (paired box 2) (eg, renal coloboma syndrome), full gene sequence pc (pyruvate carboxylase) (eg, pyruvate carboxylase deficiency), full gene sequence pcca (propionyl coa carboxylase, alpha polypeptide) (eg, propionic acidemia, type 1), full gene sequence pccb (propionyl coa carboxylase, beta polypeptide) (eg, propionic acidemia), full gene sequence pcdh15 (protocadherin-related 15) (eg, usher syndrome type 1f), duplication/deletion analysis pcsk9 (proprotein convertase subtilisin/kexin type 9) (eg, familial hypercholesterolemia), full gene sequence pdha1 (pyruvate dehydrogenase [lipoamide] alpha 1) (eg, lactic acidosis), full gene sequence pdhx (pyruvate dehydrogenase complex, component x) (eg, lactic acidosis), full gene sequence phex (phosphate-regulating endopeptidase homolog, x-linked) (eg, hypophosphatemic rickets), full gene sequence pkd2 (polycystic kidney disease 2 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence pkp2 (plakophilin 2) (eg, arrhythmogenic right ventricular dysplasia/cardiomyopathy 9), full gene sequence pnkd (paroxysmal nonkinesigenic dyskinesia) (eg, paroxysmal nonkinesigenic dyskinesia), full gene sequence polg (polymerase [dna directed], gamma) (eg, alpers-huttenlocher syndrome, autosomal dominant progressive external ophthalmoplegia), full gene sequence pomgnt1 (protein o-linked mannose beta1,2-n acetylglucosaminyltransferase) (eg, muscle-eye-							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	brain disease, walker-warburg syndrome), full gene sequence pomt1 (protein-o-mannosyltransferase 1) (eg, limb-girdle muscular dystrophy [lgmd] type 2k, walker-warburg syndrome), full gene sequence pomt2 (protein-o-mannosyltransferase 2) (eg, limb-girdle muscular dystrophy [lgmd] type 2n, walker-warburg syndrome), full gene sequence ppox (protoporphyrinogen oxidase) (eg, variegate porphyria), full gene sequence prkag2 (protein kinase, amp-activated, gamma 2 non-catalytic subunit) (eg, familial hypertrophic cardiomyopathy with wolff-parkinson-white syndrome, lethal congenital glycogen storage disease of heart), full gene sequence prkcg (protein kinase c, gamma) (eg, spinocerebellar ataxia), full gene sequence psen2 (presenilin 2 [alzheimer disease 4]) (eg, alzheimer disease), full gene sequence ptpn11 (protein tyrosine phosphatase, non-receptor type 11) (eg, noonan syndrome, leopard syndrome), full gene sequence pygm (phosphorylase, glycogen, muscle) (eg, glycogen storage disease type v, mcardle disease), full gene sequence raf1 (v-raf-1 murine leukemia viral oncogene homolog 1) (eg, leopard syndrome), full gene sequence ret (ret proto-oncogene) (eg, hirschsprung disease), full gene sequence rpe65 (retinal pigment epithelium-specific protein 65kda) (eg, retinitis pigmentosa, leber congenital amaurosis), full gene sequence ryr1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), targeted sequence analysis of exons with functionally-confirmed mutations scn4a (sodium channel, voltage-gated, type iv, alpha subunit) (eg, hyperkalemic periodic paralysis), full gene sequence scnn1a (sodium channel, nonvoltage-gated 1 alpha) (eg, pseudohypoaldosteronism), full gene sequence scnn1b (sodium channel, nonvoltage-gated 1, beta) (eg, liddle syndrome, pseudohypoaldosteronism), full gene sequence scnn1g (sodium channel, nonvoltage-gated 1, gamma) (eg, liddle syndrome, pseudohypoaldosteronism), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	sdha (succinate dehydrogenase complex, subunit a, flavoprotein [fp]) (eg, leigh syndrome, mitochondrial complex ii deficiency), full gene sequence setx (senataxin) (eg, ataxia), full gene sequence sgce (sarcoglycan, epsilon) (eg, myoclonic dystonia), full gene sequence sh3tc2 (sh3 domain and tetratricopeptide repeats 2) (eg, charcot-marie-tooth disease), full gene sequence slc9a6 (solute carrier family 9 [sodium/hydrogen exchanger], member 6) (eg, christianson syndrome), full gene sequence slc26a4 (solute carrier family 26, member 4) (eg, pendred syndrome), full gene sequence slc37a4 (solute carrier family 37 [glucose-6-phosphate transporter], member 4) (eg, glycogen storage disease type ib), full gene sequence smad4 (smad family member 4) (eg, hemorrhagic telangiectasia syndrome, juvenile polyposis), full gene sequence sos1 (son of sevenless homolog 1) (eg, noonan syndrome, gingival fibromatosis), full gene sequence spast (spastin) (eg, spastic paraplegia), full gene sequence spg7 (spastic paraplegia 7 [pure and complicated autosomal recessive]) (eg, spastic paraplegia), full gene sequence stxbp1 (syntaxin-binding protein 1) (eg, epileptic encephalopathy), full gene sequence taz (tafazzin) (eg, methylglutaconic aciduria type 2, barth syndrome), full gene sequence tcf4 (transcription factor 4) (eg, pitt-hopkins syndrome), full gene sequence th (tyrosine hydroxylase) (eg, segawa syndrome), full gene sequence tmem43 (transmembrane protein 43) (eg, arrhythmogenic right ventricular cardiomyopathy), full gene sequence tnnt2 (troponin t, type 2 [cardiac]) (eg, familial hypertrophic cardiomyopathy), full gene sequence trpc6 (transient receptor potential cation channel, subfamily c, member 6) (eg, focal segmental glomerulosclerosis), full gene sequence tsc1 (tuberous sclerosis 1) (eg, tuberous sclerosis), full gene sequence tsc2 (tuberous sclerosis 2) (eg, tuberous sclerosis), duplication/deletion analysis ube3a (ubiquitin protein ligase e3a) (eg, angelman syndrome), full							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	gene sequence umod (uromodulin) (eg, glomerulocystic kidney disease with hyperuricemia and isosthenuria), full gene sequence vwf (von willebrand factor) (von willebrand disease type 2a), extended targeted sequence analysis (eg, exons 11-16, 24-26, 51, 52) was (wiskott-aldrich syndrome [eczema-thrombocytopenia]) (eg, wiskott-aldrich syndrome), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81407	Molecular pathology procedure, level 8 (eg, analysis of 26-50 exons by dna sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform) abcc8 (atp-binding cassette, sub-family c [cftr/mrp], member 8) (eg, familial hyperinsulinism), full gene sequence agl (amylo-alpha-1, 6-glucosidase, 4-alpha-glucanotransferase) (eg, glycogen storage disease type iii), full gene sequence ahi1 (abelson helper integration site 1) (eg, joubert syndrome), full gene sequence apob (apolipoprotein b) (eg, familial hypercholesterolemia type b) full gene sequence aspm (asp [abnormal spindle] homolog, microcephaly associated [drosophila]) (eg, primary microcephaly), full gene sequence chd7 (chromodomain helicase dna binding protein 7) (eg, charge syndrome), full gene sequence col4a4 (collagen, type iv, alpha 4) (eg, alport syndrome), full gene sequence col4a5 (collagen, type iv, alpha 5) (eg, alport syndrome), duplication/deletion analysis col6a1 (collagen, type vi, alpha 1) (eg, collagen type vi-related disorders), full gene sequence col6a2 (collagen, type vi, alpha 2) (eg, collagen type vi-related disorders), full gene sequence col6a3 (collagen, type vi, alpha 3) (eg, collagen type vi-related disorders), full gene sequence crebbp (creb binding protein) (eg, rubinstein-taybi syndrome), full gene sequence f8 (coagulation factor viii) (eg, hemophilia a), full gene sequence jag1 (jagged 1) (eg, alagille syndrome), full gene sequence kdm5c (lysine [k]-specific demethylase 5c) (eg, x-linked mental retardation), full gene sequence kiaa0196 (kiaa0196) (eg, spastic paraplegia), full gene sequence l1cam (l1 cell adhesion molecule) (eg, masa syndrome, x-linked hydrocephaly), full gene sequence lamb2 (laminin, beta 2 [laminin s]) (eg, pierson syndrome), full gene sequence mybpc3 (myosin binding protein c, cardiac) (eg, familial hypertrophic cardiomyopathy), full gene sequence myh6 (myosin, heavy chain 6, cardiac muscle, alpha) (eg, familial dilated cardiomyopathy), full	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	gene sequence myh7 (myosin, heavy chain 7, cardiac muscle, beta) (eg, familial hypertrophic cardiomyopathy, liang distal myopathy), full gene sequence myo7a (myosin viia) (eg, usher syndrome, type 1), full gene sequence notch1 (notch 1) (eg, aortic valve disease), full gene sequence nphs1 (nephrosis 1, congenital, finnish type [nephrin]) (eg, congenital finnish nephrosis), full gene sequence opa1 (optic atrophy 1) (eg, optic atrophy), full gene sequence pcdh15 (protocadherin-related 15) (eg, usher syndrome, type 1), full gene sequence pkd1 (polycystic kidney disease 1 [autosomal dominant]) (eg, polycystic kidney disease), full gene sequence plce1 (phospholipase c, epsilon 1) (eg, nephrotic syndrome type 3), full gene sequence scn1a (sodium channel, voltage-gated, type 1, alpha subunit) (eg, generalized epilepsy with febrile seizures), full gene sequence scn5a (sodium channel, voltage-gated, type v, alpha subunit) (eg, familial dilated cardiomyopathy), full gene sequence slc12a1 (solute carrier family 12 [sodium/potassium/chloride transporters], member 1) (eg, bartter syndrome), full gene sequence slc12a3 (solute carrier family 12 [sodium/chloride transporters], member 3) (eg, gitelman syndrome), full gene sequence spg11 (spastic paraplegia 11 [autosomal recessive]) (eg, spastic paraplegia), full gene sequence sptbn2 (spectrin, beta, non-erythrocytic 2) (eg, spinocerebellar ataxia), full gene sequence tmem67 (transmembrane protein 67) (eg, joubert syndrome), full gene sequence tsc2 (tuberous sclerosis 2) (eg, tuberous sclerosis), full gene sequence ush1c (usher syndrome 1c [autosomal recessive, severe]) (eg, usher syndrome, type 1), full gene sequence vps13b (vacuolar protein sorting 13 homolog b [yeast]) (eg, cohen syndrome), duplication/deletion analysis wdr62 (wd repeat domain 62) (eg, primary autosomal recessive microcephaly), full gene sequence							

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
81408	Molecular pathology procedure, level 9 (eg, analysis of >50 exons in a single gene by dna sequence analysis) abca4 (atp-binding cassette, sub-family a [abc1], member 4) (eg, stargardt disease, age-related macular degeneration), full gene sequence atm (ataxia telangiectasia mutated) (eg, ataxia telangiectasia), full gene sequence cdh23 (cadherin-related 23) (eg, usher syndrome, type 1), full gene sequence cep290 (centrosomal protein 290kda) (eg, joubert syndrome), full gene sequence col1a1 (collagen, type i, alpha 1) (eg, osteogenesis imperfecta, type i), full gene sequence col1a2 (collagen, type i, alpha 2) (eg, osteogenesis imperfecta, type i), full gene sequence col4a1 (collagen, type iv, alpha 1) (eg, brain small-vessel disease with hemorrhage), full gene sequence col4a3 (collagen, type iv, alpha 3 [goodpasture antigen]) (eg, alport syndrome), full gene sequence col4a5 (collagen, type iv, alpha 5) (eg, alport syndrome), full gene sequence dmd (dystrophin) (eg, duchenne/becker muscular dystrophy), full gene sequence dysf (dysferlin, limb girdle muscular dystrophy 2b [autosomal recessive]) (eg, limb-girdle muscular dystrophy), full gene sequence fbn1 (fibrillin 1) (eg, marfan syndrome), full gene sequence itpr1 (inositol 1,4,5-trisphosphate receptor, type 1) (eg, spinocerebellar ataxia), full gene sequence lama2 (laminin, alpha 2) (eg, congenital muscular dystrophy), full gene sequence lrrk2 (leucine-rich repeat kinase 2) (eg, parkinson disease), full gene sequence myh11 (myosin, heavy chain 11, smooth muscle) (eg, thoracic aortic aneurysms and aortic dissections), full gene sequence neb (nebulin) (eg, nemaline myopathy 2), full gene sequence nf1 (neurofibromin 1) (eg, neurofibromatosis, type 1), full gene sequence pkhd1 (polycystic kidney and hepatic disease 1) (eg, autosomal recessive polycystic kidney disease), full gene sequence ryr1 (ryanodine receptor 1, skeletal) (eg, malignant hyperthermia), full gene sequence ryr2 (ryanodine receptor 2 [cardiac]) (eg, catecholaminergic polymorphic ventricular tachycardia,	Apr 2011	Molecular Pathology - Tier 2	16	CPT 2012		Removed. Final Rule for 2013 stated molecular pathology services will be paid for under CLFS not MFS.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
	arrhythmogenic right ventricular dysplasia), full gene sequence or targeted sequence analysis of > 50 exons ush2a (usher syndrome 2a [autosomal recessive, mild]) (eg, usher syndrome, type 2), full gene sequence vps13b (vacuolar protein sorting 13 homolog b [yeast]) (eg, cohen syndrome), full gene sequence vwf (von willebrand factor) (eg, von willebrand disease types 1 and 3), full gene sequence							
86152	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood);	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	October 2016	Remove from list, part of CLFS.	☑
86153	Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required	Apr 2012	Cell Enumeration Circulating Tumor Cells	25	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88363	Examination and selection of retrieved archival (ie, previously diagnosed) tissue(s) for molecular analysis (eg, kras mutational analysis)	Feb 2010	Archival Retrieval for Mutational Analysis	17	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	Jan 2013	Optical Endomicroscopy	15	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑
88380	Microdissection (ie, sample preparation of microscopically identified target); laser capture	Feb 2007	Manual Microdisection	12	CPT 2008	September 2011	Survey for January 2014 (added 88380 as part of the family).	☑
88381	Microdissection (ie, sample preparation of microscopically identified target); manual	Feb 2007	Manual Microdisection	12	CPT 2008	September 2013	Survey for January 2014 (added 88380 as part of the family).	☑
88384	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
88385	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88386	Code Deleted	Apr 2005	Multiple Molecular Marker Array-Based Evaluation	30	CPT 2006	September 2010	Remove, code does not need to be re-evaluated	☑
88387	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); each tissue preparation (eg, a	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
88388	Macroscopic examination, dissection, and preparation of tissue for non-microscopic analytical studies (eg, nucleic acid-based molecular studies); in conjunction with a touch imprint, intraoperative consultation, or frozen section, each tissue preparation (eg, a single lymph node) (list separately in addition to code for primary procedure)	Apr 2009	Tissue Examination for Molecular Studies	21	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
90769	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90770	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑
90771	Code Deleted CPT 2009	Apr 2007	Immune Globulin Subcutaneous Infusion	H	CPT 2008	September 2011	Code Deleted CPT 2009	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
90867	Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; initial, including cortical mapping, motor threshold determination, delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	January 2024	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (January 2024). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐
90868	Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent delivery and management, per session	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	January 2024	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (January 2024). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
90869	Therapeutic repetitive transcranial magnetic stimulation (tms) treatment; subsequent motor threshold re-determination with delivery and management	Feb 2011	Transcranial Magnetic Stimulation	15	CPT 2012	January 2024	Remain on the screens in which they were identified (Contractor Priced High Volume and New Technology/New Services) and the Workgroup will review again in 3 years (January 2024). When these codes are moved from contractor priced to the assignment to RVUs the issues around the direct to indirect practice expense ratio specific to codes 90867-90869 should be addressed.	☐
91112	Gastrointestinal transit and pressure measurement, stomach through colon, wireless capsule, with interpretation and report	Apr 2012	Wireless Motility Capsule	27	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
91113	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), colon, with interpretation and report	Jan 2021	Colon Capsule Endoscopy	21	CPT 2022	January 2026		☐
91117	Colon motility (manometric) study, minimum 6 hours continuous recording (including provocation tests, eg, meal, intracolonic balloon distension, pharmacologic agents, if performed), with interpretation and report	Apr 2010	Colon Motility	21	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
91200	Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report	April 2015	Liver Elastography	19	CPT 2016	January 2020	Surveyed for January 2020. Decreased.	☑
92065	Orthoptic training	Apr 2021	Orthoptic Training	10	CPT 2023	January 2027		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
920XX		Apr 2021	Orthoptic Training	10	CPT 2023	January 2027		☐
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	Apr 2010	Anterior Segment Imaging	22	CPT 2011	April 2015	Survey for October 2015. The RUC noted that it is the specialty societies decision whether 92133 and 92134 need to be surveyed with this service.	☑
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	Apr 2010	Computerized Scanning Ophthalmology Diagnostic Imaging	23	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report	Apr 2014	Corneal Hysteresis Determination	23	CPT 2015	October 2018	Survey for January 2019.	☑
92227	Imaging of retina for detection or monitoring of disease; with remote clinical staff review and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	January 2025		☐
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	Apr 2010	Diabetic Retinopathy Imaging	24	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
92228	Imaging of retina for detection or monitoring of disease; with remote physician or other qualified health care professional interpretation and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral	Oct 2019	Remote Retinal Imaging	09	CPT 2021	January 2025		☐
92284	Dark adaptation examination with interpretation and report	Apr 2021	Dark Adaption Eye Exam	20	CPT 2023	October 2023	The RUC will review the typical technology used to perform this service when it is next re-evaluated, acknowledging that the device included in proposed direct practice costs recently was very recently replaced with a newer technology.	☐
92517	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	January 2025		☐
92518	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; ocular (ovemp)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	January 2025		☐
92519	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp) and ocular (ovemp)	Apr 2019	Vestibular Evoked Myogenic Potential (VEMP) Testing	07	CPT 2021	January 2025		☐
93050	Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive	Apr 2015	Arterial Pressure Waveform Analysis	20	CPT 2016	April 2022	Review in 2 years (January 2022)	☐
93241	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93242	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93243	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; scanning analysis with report	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93244	External electrocardiographic recording for more than 48 hours up to 7 days by continuous rhythm recording and storage; review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93245	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93246	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; recording (includes connection and initial recording)	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93247	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; scanning analysis with report	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93248	External electrocardiographic recording for more than 7 days up to 15 days by continuous rhythm recording and storage; review and interpretation	Jan 2020	External Extended ECG Monitoring	18	CPT 2021	January 2025		☐
93260	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; implantable subcutaneous lead defibrillator system	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93261	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable subcutaneous lead defibrillator system	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
93264	Remote monitoring of a wireless pulmonary artery pressure sensor for up to 30 days, including at least weekly downloads of pulmonary artery pressure recordings, interpretation(s), trend analysis, and report(s) by a physician or other qualified health care professional	Jan 2018	Pulmonary Wireless Pressure Sensor Services	08	CPT 2019	January 2023		☐
93279	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead pacemaker system or leadless pacemaker system in one cardiac chamber	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93280	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93281	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93282	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; single lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93283	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; dual lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93284	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; multiple lead transvenous implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93285	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional; subcutaneous cardiac rhythm monitor system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93286	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93287	Peri-procedural device evaluation (in person) and programming of device system parameters before or after a surgery, procedure, or test with analysis, review and report by a physician or other qualified health care professional; single, dual, or multiple lead implantable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93288	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system, or leadless pacemaker system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93289	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead transvenous implantable defibrillator system, including analysis of heart rhythm derived data elements	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93290	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93291	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; subcutaneous cardiac rhythm monitor system, including heart rhythm derived data analysis	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93292	Interrogation device evaluation (in person) with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter; wearable defibrillator system	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93293	Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with analysis, review and report(s) by a physician or other qualified health care professional, up to 90 days	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93294	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, or leadless pacemaker system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93295	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93296	Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system, leadless pacemaker system, or implantable defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93297	Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular physiologic monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93298	Interrogation device evaluation(s), (remote) up to 30 days; subcutaneous cardiac rhythm monitor system, including analysis of recorded heart rhythm data, analysis, review(s) and report(s) by a physician or other qualified health care professional	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93299	Code Deleted CPT 2020	Apr 2008	Cardiac Device Monitoring	23	CPT 2009	September 2012	Ad Hoc Workgroup developed to determine how to address the work neutrality failure and estabhis guidelines for further RAW review of retrospective work neutralilty.	☑
93319	3d echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) (eg, cardiac chambers and valves, left atrial appendage, interatrial septum, interventricular septum) and function, when performed (list separately in addition to code for echocardiographic imaging)	Oct 2020	3D Imaging of Cardiac Structures	09	CPT 2022	January 2026		☐
93462	Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (list separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
93463	Pharmacologic agent administration (eg, inhaled nitric oxide, intravenous infusion of nitroprusside, dobutamine, milrinone, or other agent) including assessing hemodynamic measurements before, during, after and repeat pharmacologic agent administration, when performed (list separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93464	Physiologic exercise study (eg, bicycle or arm ergometry) including assessing hemodynamic measurements before and after (list separately in addition to code for primary procedure)	Apr 2010	Diagnostic Cardiac Catheterization	26	CPT 2011	September 2014	Remove from list, no demonstrated technology diffusions that impacts work or practice expense.	☑
93583	Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed	Jan 2013	Percutaneous Alcohol Ablation of Septum	17	CPT 2014	October 2017	Remove from list, no demonstrated techology diffusion that impacts work or practice expense.	☑
93590	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93591	Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93592	Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (list separately in addition to code for primary procedure)	Jan 2016	Closure of Paravalvular Leak	22	CPT 2017	October 2020	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
93593	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
93594	Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; abnormal native connections	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
93595	Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
93596	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
93597	Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); abnormal native connections	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
93598	Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects (list separately in addition to code for primary procedure)	Oct 2020	Cardiac Catheterization for Congenital Defects	10	CPT 2022	January 2026		☐
93644	Electrophysiologic evaluation of subcutaneous implantable defibrillator (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	Apr 2014	Subcutaneous Implantable Defibrillator Procedures	09	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
93982	Code Deleted	Apr 2007	Wireless Pressure Sensor Implantation	25	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
93XX0		Oct 2021	Pulmonary Angiography	08	CPT 2023	January 2027		☐
93XX1		Oct 2021	Pulmonary Angiography	08	CPT 2023	January 2027		☐
93XX2		Oct 2021	Pulmonary Angiography	08	CPT 2023	January 2027		☐
93XX3		Oct 2021	Pulmonary Angiography	08	CPT 2023	January 2027		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
94012	Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
94013	Measurement of lung volumes (ie, functional residual capacity [frc], forced vital capacity [fvc], and expiratory reserve volume [erv]) in an infant or child through 2 years of age	Apr 2009	Infant Pulmonary Function Testing	23	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
94625	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)	Jan 2021	Outpatient Pulmonary Rehabilitation Services	23	CPT 2022	January 2026		☐
94626	Physician or other qualified health care professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)	Jan 2021	Outpatient Pulmonary Rehabilitation Services	23	CPT 2022	January 2026		☐
95700	Electroencephalogram (eeg) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by eeg technologist, minimum of 8 channels	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95705	Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, 2-12 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95706	Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, 2-12 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95707	Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95708	Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, each increment of 12-26 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95709	Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95710	Electroencephalogram (eeg), without video, review of data, technical description by eeg technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95711	Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, 2-12 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95712	Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, 2-12 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95713	Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, 2-12 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95714	Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, each increment of 12-26 hours; unmonitored	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95715	Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, each increment of 12-26 hours; with intermittent monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95716	Electroencephalogram with video (veeg), review of data, technical description by eeg technologist, each increment of 12-26 hours; with continuous, real-time monitoring and maintenance	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95717	Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of eeg recording; without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95718	Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of eeg recording; with video (veeg)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95719	Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of eeg recording, interpretation and report after each 24-hour period; without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95720	Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of eeg recording, interpretation and report after each 24-hour period; with video (veeg)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95721	Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of eeg recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95722	Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of eeg recording, with video (veeg)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95723	Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of eeg recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95724	Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 60 hours, up to 84 hours of eeg recording, with video (veeg)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95725	Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of eeg recording, without video	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐
95726	Electroencephalogram (eeg), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 84 hours of eeg recording, with video (veeg)	Oct 2018	Long-Term EEG Monitoring	13	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95800	Sleep study, unattended, simultaneous recording; heart rate, oxygen saturation, respiratory analysis (eg, by airflow or peripheral arterial tone), and sleep time	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95801	Sleep study, unattended, simultaneous recording; minimum of heart rate, oxygen saturation, and respiratory analysis (eg, by airflow or peripheral arterial tone)	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95803	Actigraphy testing, recording, analysis, interpretation, and report (minimum of 72 hours to 14 consecutive days of recording)	Apr 2008	Actigraphy Sleep Assessment	25	CPT 2009	September 2012	Remove, code does not need to be re-evaluated	☑
95806	Sleep study, unattended, simultaneous recording of, heart rate, oxygen saturation, respiratory airflow, and respiratory effort (eg, thoracoabdominal movement)	Apr 2010	Sleep Testing	28	CPT 2011	October 2016	Survey for physician work and review direct practice expense inputs for April 2017. These services have continued to grow and the inclusion of the PACS workstation equipment was questioned.	☑
95836	Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days	Jan 2018	Electrocorticography	18	CPT 2019	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95905	Motor and/or sensory nerve conduction, using preconfigured electrode array(s), amplitude and latency/velocity study, each limb, includes f-wave study when performed, with interpretation and report	Feb 2009	Nerve Conduction Tests	18	CPT 2010	September 2013	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95940	Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (list separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95941	Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (list separately in addition to code for primary procedure)	Jan 2012	Intraoperative Neurophysiology Monitoring	12	CPT 2013	October 2016	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.	☑
95980	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; intraoperative, with programming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
95981	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
95982	Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, with reprogramming	Apr 2007	Electronic Analysis of Implanted Neurostimulator Pulse Generator System	I	CPT 2008	September 2011	Remove, code does not need to be re-evaluated	☑
959XX		Oct 2021	Quantitative Pupillometry Services	09	CPT 2023	January 2027		☐
96020	Neurofunctional testing selection and administration during noninvasive imaging functional brain mapping, with test administered entirely by a physician or other qualified health care professional (ie, psychologist), with review of test results and report	Feb 2006	Functional MRI	15	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
96904	Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	Feb 2006	Whole Body Integumentary Photography	19	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
96931	Reflectance confocal microscopy (rcm) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96932	Reflectance confocal microscopy (rcm) for cellular and sub-cellular imaging of skin; image acquisition only, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96933	Reflectance confocal microscopy (rcm) for cellular and sub-cellular imaging of skin; interpretation and report only, first lesion	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96934	Reflectance confocal microscopy (rcm) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (list separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
96935	Reflectance confocal microscopy (rcm) for cellular and sub-cellular imaging of skin; image acquisition only, each additional lesion (list separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
96936	Reflectance confocal microscopy (rcm) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (list separately in addition to code for primary procedure)	Oct 2015	Reflectance Confocal Microscopy	06	CPT 2017	October 2020	Review in 3 years (October 2023).	☐
97605	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (dme), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
97606	Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (dme), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
97607	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐
97608	Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters	Jan 2014	Negative Wound Pressure Therapy	17	CPT 2015	April 2022	In October 2018, RUC recommended to review again after 3 more years of data (2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
97610	Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day	Oct 2013	HCPAC - Ultrasonic Wound Assessment	17	CPT 2015	October 2018	Survey for January 2019.	☑
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Apr 2007	Non Face-to-Face Qualified Healthcare Professional Services	U	CPT 2008	September 2011	Remove, not covered by Medicare	☑
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	January 2024		☐
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	41	CPT 2020	January 2024		☐
98975	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2026		☐
98976	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2026		☐
98977	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days	Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2026		☐
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes	Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2026		☐
98981	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes (list separately in addition to code for primary procedure)	Jan 2021	Remote Therapeutic Monitoring	24	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. when using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. when using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. when using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. when using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. when using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. when using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. when using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. when using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐
99363	Code Deleted	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
99364	Code Deleted	Apr 2006	Anticoagulant Management Services	I	CPT 2007	September 2010	Remove, code does not need to be re-evaluated	☑
99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (list separately in addition to codes 99205, 99215 for office or other outpatient evaluation and management services)	Apr 2019	Office Visits	09	CPT 2021	January 2025		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	January 2024		☐
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	January 2024		☐
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	Jan 2019	Online Digital Evaluation Service (e-Visit)	21	CPT 2020	January 2024		☐
99424	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99425	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐
99426	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99427	Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐
99437	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 30 minutes by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99439	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	Feb 2007	Non Face-to-Face Services	16	CPT 2008	September 2011	Remove, not covered by Medicare	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99446	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99447	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99448	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99449	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Oct 2012	Interprofessional Telephone Consultative Services	14	CPT 2014	October 2016	Reaffirmed RUC recommendation	☑
99451	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	Jan 2018	Interprofessional Internet Consultation	21	CPT 2019	January 2023		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99452	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes	Jan 2018	Interprofessional Internet Consultation	21	CPT 2019	January 2023		☐
99453	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	January 2023		☐
99454	Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	January 2023		☐
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes	Jan 2018	Chronic Care Remote Physiologic Monitoring	20	CPT 2019	January 2024		☐
99458	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (list separately in addition to code for primary procedure)	Jan 2019	Chronic Care Remote Physiologic Monitoring	20	CPT 2020	January 2024		☐
99474	Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient	Jan 2019	Self-Measured Blood Pressure Monitoring	19	CPT 2020	January 2024		☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales, behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes, facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation, and continuity of care with a designated member of the care team.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	April 2022		☐
99487	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2013	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99488	Code Deleted	Oct 2012	Complex Chronic Care Coordination Services	09	CPT 2013	October 2017	Code Deleted	☑

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99489	Complex chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure)	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2013	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99490	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2015	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐
99491	Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.	Jan 2021	Principal Care Management (PCM) & Chronic Care Management (CCM)	25	CPT 2022	January 2026	Was surveyed for January 2021 with the principal care management codes. The RUC noted that the CCM codes should also be re-reviewed at that time, primarily because the clinical staff time survey responses were not obtained for the 2021 review.	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional, initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan, review by the psychiatric consultant with modifications of the plan if recommended, entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant, and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	January 2023	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the January 2023 Relativity Assessment Workgroup meeting. The Workgroup recommends postponing the new	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							technology/new services review until January 2023, after the CPT Assistant article has time to take effect.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation, participation in weekly caseload consultation with the psychiatric consultant, ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers, additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant, provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies, monitoring of patient outcomes using validated rating scales, and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	January 2023	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the January 2023 Relativity Assessment Workgroup meeting. The Workgroup recommends postponing the new	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							technology/new services review until January 2023, after the CPT Assistant article has time to take effect.	

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (list separately in addition to code for primary procedure)	Jan 2017	Psychiatric Collaborative Care Management Services	20	CPT 2018	January 2023	In January 2020, the RUC identified Psychiatric Collaborative Care Management Services (CPT codes 99492, 99493 and 99494) via the work neutrality process. These codes show a 468% increase in work RVUs for 2018. In reviewing the utilization data for these services, it appears one independent clinic is performing most of these services in the pediatric population. The Workgroup recommends that CMS investigate the reporting of services by this specific independent clinic. The specialty society indicated, and the Workgroup agreed, that a new CPT Assistant article on the appropriate usage of these codes be developed in 2020. This family is also scheduled on the new technology/new services list for review at the January 2023 Relativity Assessment Workgroup meeting. The Workgroup recommends postponing the new	☐

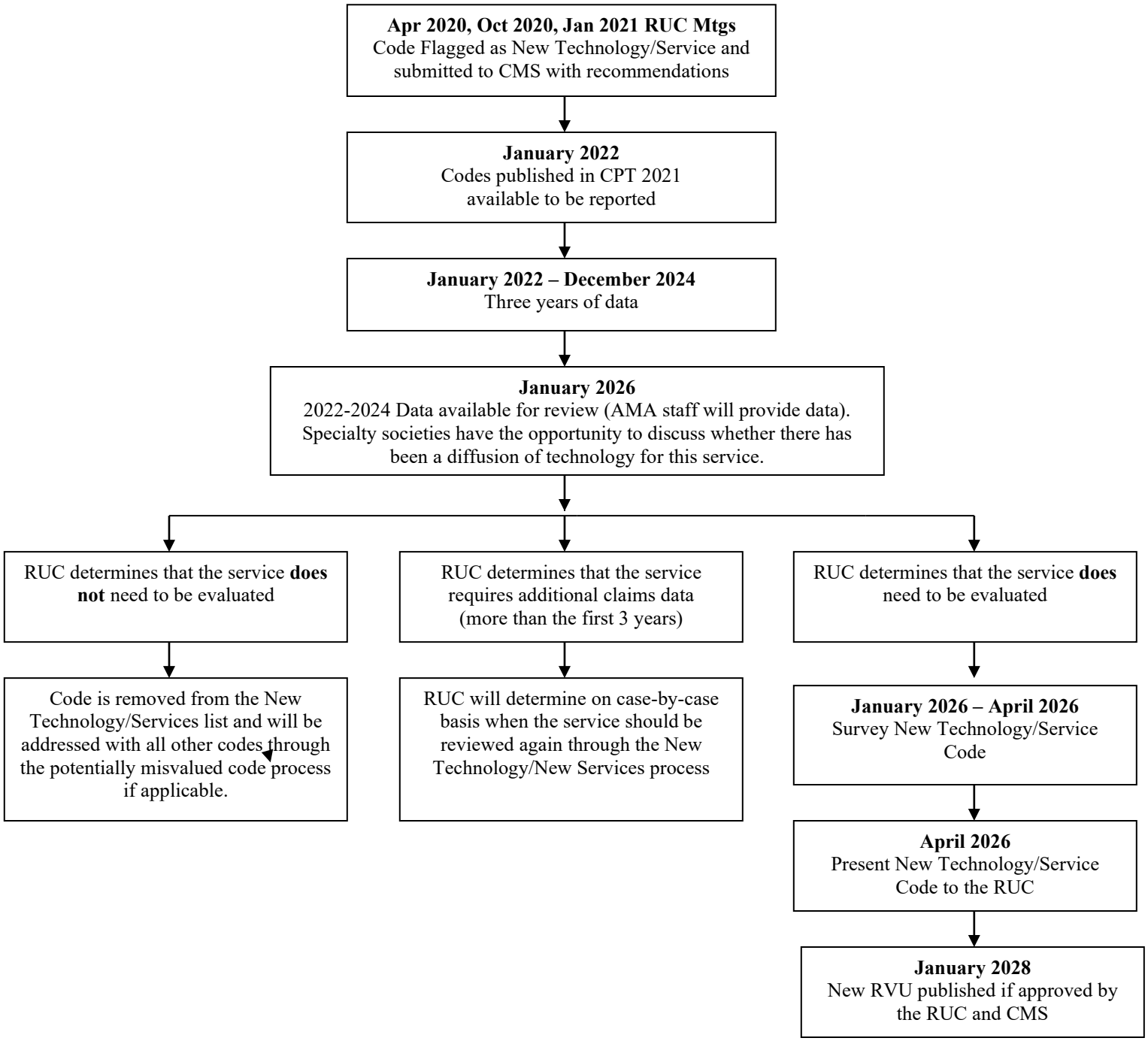
CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
							technology/new services review until January 2023, after the CPT Assistant article has time to take effect.	
99495	Transitional care management services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge	Oct 2012	Transitional Care Management Services	08	CPT 2013	October 2017	Survey for October 2018	☑
99496	Transitional care management services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge	Oct 2012	Transitional Care Management Services	08	CPT 2013	October 2017	Survey for October 2018	☑
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate	Jan 2014	Advance Care Planning	19	CPT 2015	April 2022	Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (January 2022).	☐
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)	Jan 2014	Advance Care Planning	19	CPT 2015	April 2022	Review in 2 years (October 2019). In Oct 2019, indicated to review in another 2 years (January 2022).	☐

CPT Code	Long Descriptor	RUC Meeting	Issue	Tab	CPT Year	Date to Re-Review	RUC Rec	Complete
G0445	High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes		Fecal Bacteriotherapy		CPT 2013	October 2018		☑

New Technology/Services Timeline

1. Code is identified as a new technology/service at the RUC meeting in which it is initially reviewed.
2. Code is flagged in the next version of the RUC database with date to be reviewed
3. Code will be reviewed in 5 years (depending on what meeting in the CPT/RUC cycle it is initially reviewed) after at least three years of data are available.

Example



Society	Acronym
AMDA-The Society for Post-Acute and Long-Term Care Medicine	AMDA
American Academy of Allergy, Asthma & Immunology	AAAAI
American Academy of Child and Adolescent Psychiatry	AACAP
American Academy of Dermatology Association	AADA
American Academy of Family Physicians	AAFP
American Academy of Hospice and Palliative Medicine	AAHPM
American Academy of Neurology	AAN
American Academy of Ophthalmology	AAO
American Academy of Orthopaedic Surgeons	AAOS
American Academy of Otolaryngic Allergy	AAOA
American Academy of Otolaryngology - Head and Neck Surgery	AAO-HNS
American Academy of Pain Medicine	AAPM
American Academy of Pediatrics	AAP
American Academy of Physical Medicine & Rehabilitation	AAPMR
American Academy of Sleep Medicine	AASM
American Association for Thoracic Surgery	AATS
American Association of Clinical Endocrinologists	AACE
American Association of Clinical Urologist, Inc.	AACU
American Association of Hip and Knee Surgeons	AAHKS
American Association of Neurological Surgeons	AANS
American Association of Neuromuscular & Electrodiagnostic Medicine	AANEM
American Association of Oral and Maxillofacial Surgeons	AAOMS
American Burn Association	ABA

Society	Acronym
American Clinical Neurophysiology Society	ACNS
American College of Allergy, Asthma & Immunology	ACAAI
American College of Cardiology	ACC
American College of Chest Physicians	CHEST
American College of Emergency Physicians	ACEP
American College of Gastroenterology	ACG
American College of Medical Genetics	ACMG
American College of Mohs Surgery	ACMS
American College of Nuclear Medicine	ACNM
American College of Obstetricians and Gynecologists	ACOG
American College of Physicians	ACP
American College of Radiation Oncology	ACRO
American College of Radiology	ACR
American College of Rheumatology	ACRh
American College of Surgeons	ACS
American Dental Association	ADA
American Gastroenterological Association	AGA
American Geriatrics Society	AGS
American Orthopaedic Foot and Ankle Society	AOFAS
American Osteopathic Association	AOA
American Pediatric Surgical Association	APSA
American Psychiatric Association	APA
American Rhinologic Society	ARS

Society	Acronym
American Roentgen Ray Society	ARRS
American Society for Clinical Pathology	ASCP
American Society for Dermatologic Surgery	ASDS
American Society for Gastrointestinal Endoscopy	ASGE
American Society for Radiation Oncology	ASTRO
American Society for Reproductive Medicine	ASRM
American Society for Surgery of the Hand	ASSH
American Society for Transplantation and Cellular Therapy	ASTCT
American Society of Addiction Medicine	ASAM
American Society of Anesthesiologists	ASA
American Society of Breast Surgeons	ASBS
American Society of Cataract and Refractive Surgery	ASCRS(cat)
American Society of Clinical Oncology	ASCO
American Society of Colon and Rectal Surgeons	ASCRS(col)
American Society of Cytopathology	ASC
American Society of Dermatopathology	ASDP
American Society of Echocardiography	ASE
American Society of General Surgeons	ASGS
American Society of Hematology	ASH
American Society of Interventional Pain Physicians	ASIPP
American Society of Neuroimaging	ASN
American Society of Neuroradiology	ASNR
American Society of Plastic Surgeons	ASPS

Society	Acronym
American Society of Retina Specialists	ASRS
American Society of Transplant Surgeons	ASTS
American Thoracic Society	ATS
American Urological Association	AUA
American Vein and Lymphatic Society	AVLS
American Women's Medical Association	AWMA
Association of University Radiologists	AUR
College of American Pathologists	CAP
Congress of Neurological Surgeons	CNS
Heart Rhythm Society	HRS
Infectious Diseases Society of America	IDSA
International Society for the Advancement of Spine Surgery	ISASS
National Association of Medical Examiners	NAME
North American Neuromodulation Society	NANS
North American Spine Society	NASS
Obesity Medicine Association	OMA
Radiological Society of North America	RSNA
Renal Physicians Association	RPA
Society for Vascular Surgery	SVS
Society of American Gastrointestinal and Endoscopic Surgeons	SAGES
Society of Critical Care Medicine	SCCM
Society of Hospital Medicine	SHM
Society of Interventional Radiology	SIR

Society	Acronym
Society of Laparoscopic & Robotic Surgeons	SLS
Society of Nuclear Medicine and Molecular Imaging	SNMMI
Society of Thoracic Surgeons	STS
The Endocrine Society	ES
The Society for Cardiovascular Angiography and Interventions	SCAI
The Spine Intervention Society	SIS
Underseas and Hyperbaric Medical Society	UHMS

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2021

Endovascular Pulmonary Arterial Revascularization – Tab 4

In February 2021, the CPT Editorial Panel approved a new family of Category I CPT codes to describe percutaneous endovascular repair of pulmonary artery stenosis (PAS) by stent replacement, a developing approach that has improved outcomes for some patients, particularly small children. Since other peripheral vascular angioplasty and stenting interventions were formerly the only possible method of procedure for treating PAS, endovascular pulmonary repair is not uniquely delineated in CPT due to the large number of patients treated for other pathologies with any of the existing codes that are used to report this work. CPT codes 33900-33904 were surveyed together for the October 2021 RUC meeting.

Over the last 20 years, advancements in stent technology have provided physicians with the opportunity to perform endovascular repair of pulmonary artery stenosis by stent placement on a broader patient population, specifically now to small children. Stents are smaller and conducive to a wider range of medical procedures, and physicians are no longer limited to only using balloon angioplasty for treating PAS in children. Therefore, the specialty societies noted, and the RUC agreed, that for procedures involving pulmonary artery stenosis on pediatric patients, the application of endovascular repair using a stent was an obstacle and a technological impossibility until more recently.

33900 ***Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral***
The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 14.00 for CPT code 33900 which falls appropriately between the top two key reference services (KRS). The RUC recommends 50 minutes of pre-service evaluation, 6 minutes of per-service positioning, 15 minutes of pre-service scrub/dress/wait time, 90 minutes of intra-service time and 45 minutes of immediate post-service time. The specialties noted that the pre-service time for pediatric patients includes additional time to review imaging evaluations, careful positioning due to the potential for multiple access points of intervention, and comprehensive discussion with the patient's family about the procedure. Similarly, the post-service time includes additional time to explain the pathology of the child to the parent. In addition, the post-service period time typically includes time to diagram congenital heart defect(s) in the electronic health record (EHR) and complete data submission to the appropriate national registry, as available/appropriate.

To justify the value of 14.00, the RUC compared the surveyed code to key reference codes 92928 *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch* (work RVU= 10.96, 76 minutes of intra-service time, and 135 minutes of total time) and 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, 120 minutes of intra-service time and 210 minutes of total time) and determined that the surveyed code appropriately falls between these services based on the physician work and intensity required to perform these services and therefore maintains relativity. The RUC explained that CPT code 33900 is a unilateral procedure where the patient has normal native connections; the intensity required to perform this service is consistent with the supporting references codes and comparable to the median survey results.

For additional support, the RUC referenced the Multi-Specialty Points of Comparison (MPC) code 37244 *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation* (work RVU= 13.75, 90 minutes of intra-service time and 166 minutes of total time) and CPT code 33340 *Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation* (work RVU= 14.00, 90 minutes intra-service time, and 183 minutes of total time) and noted that the surveyed code exactly matches the intra-service time established for these two supplementary codes. The intensity to perform the service for the MPC, comparison code, and surveyed code appropriately align in terms of their work RVU, therefore maintaining relativity in the Medicare Physician Payment Schedule. **The RUC recommends a work RVU of 14.00 for CPT code 33900.**

33901 ***Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, bilateral***
The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 18.00 for CPT code 33901. The RUC recommends 50 minutes of pre-service evaluation, 6 minutes of per-service positioning, 15 minutes of pre-service scrub/dress/wait, 120 minutes of intra-service time and 45 minutes of immediate post-service time. The specialties noted that the pre-service time for pediatric patients includes additional time to review imaging evaluations, careful positioning due to the potential for multiple access points of intervention, and comprehensive discussion with the patient's family about the procedure. Similarly, the post-service time includes additional time to explain the pathology of the child to the parent. In addition, the post-service period time typically includes time to diagram congenital heart defect(s) in the EHR and complete data submission to the appropriate national registry, as available/appropriate. A primary distinction between 33901 and 33900 is the 30-minute increase in intra-service time, which is attributed to the procedure becoming more medically complex when advancing from unilateral to bilateral in nature.

To justify the value of 18.00, the RUC compared the surveyed code to key reference code CPT codes 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, 120 minutes of intra-service time, and 210 minutes of total time) and determined that the surveyed code is appropriately supported by this reference service based on the similar physician work and time required to perform these services. Being that this a bilateral procedure for a patient with normal native connections, the 120-minute intra-service time allocation for 33901, along with the measured intensity required to perform this service, are consistent with the supporting reference codes and comparable to the median from the survey results.

For additional support, the RUC referenced CPT code 93591 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve* (work RVU = 17.97, 120 minutes intra-service time, and 208 minutes of total time). The RUC selected this reference code based on the similarities of physician work required to perform the service compared to the surveyed code. While the codes have identical intra-service time, the total time for the surveyed code is slightly higher, suggesting that they should be valued similarly, although the surveyed code should maintain a slightly higher work RVU. **The RUC recommends a work RVU of 18.00 for CPT code 33901.**

33902 ***Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, unilateral***
The RUC reviewed the survey results from 34 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 17.33 for CPT code 33902. The RUC recommends 50 minutes of pre-service evaluation, 6 minutes of per-service positioning, 15 minutes of pre-service scrub/dress/wait, 90 minutes of intra-service time and 48 minutes of immediate post-service time. The specialties noted that the pre-service time for pediatric patients includes additional time to review imaging evaluations, careful positioning due to the potential for multiple access points of intervention, and comprehensive discussion with the patient's family about the procedure. Similarly, the post-service time includes additional time to explain the pathology of the child to the parent. In addition, the post-service period time typically includes time to diagram congenital heart defect(s) in the EHR and complete data submission to the appropriate national registry, as available/appropriate.

To justify the value of 17.33, the RUC compared the surveyed code to CPT codes 93590 *Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve* (work RVU= 21.70, 135 minutes of intra-service time, and 223 minutes of total time) and 37231 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed* (work RVU= 14.75, 135 minutes of intra-service time, and 203 minutes of total time) and determined that the surveyed code appropriately falls between these services based on the physician work and time required to perform these services. The RUC discerned that 33900 and 33902 are both unilateral procedures and require 90 minutes of intra-service time; however, there is larger amount of physician work required due to increased intensity and greater medical complexity of these services when patients have abnormal connections versus normal native connections.

For additional support, the RUC also referenced CPT code 93580 *Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant* (work RVU= 17.97, 120 minutes intra-service time, and 210 minutes of total time) which has similar total time to the surveyed code but a lower intensity. The RUC recognizes similarities between these services, although the surveyed code still requires more physician work to perform the service as the RUC discerned above. Additionally, it was determined that the surveyed code was valued appropriately within the family to maintain relativity based on the description of work related to abnormal connections. **For this reason, the RUC recommends a work RVU of 17.33 for CPT code 33902.**

33903 ***Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, bilateral***
The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 20.00 for CPT code 33903. The RUC recommends 50 minutes of pre-service evaluation, 6 minutes of per-service positioning, 15 minutes of pre-service scrub/dress/wait, 120 minutes of intra-service time and 50 minutes of immediate post-service time. The specialties noted that the pre-service time for pediatric patients includes additional time to review imaging evaluations, careful positioning due to the potential for multiple access points of intervention, and comprehensive discussion with the patient's family about the procedure. Similarly, the post-service time includes additional time to explain the pathology of the child to the parent. In addition, the post-service period time typically includes time to diagram congenital heart defect(s) in the EHR and complete data submission to the appropriate national registry, as available/appropriate. A primary distinction between 33903 and 33902 is the 30-minute increase in intra-service time, which is attributed to the procedure becoming more medically complex when advancing from unilateral to bilateral in nature.

To justify the value of 20.00, the RUC compared the surveyed code to top key reference code 93581 *Percutaneous transcatheter closure of a congenital ventricular septal defect with implant* (work RVU= 24.39, 180 minutes of intra-service time, and 270 minutes of total time) and noted

that the surveyed code requires less physician work and time to perform and is thus appropriately valued lower. The RUC also compared the surveyed code to the second top key reference code 92928 *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch* (work RVU= 10.96, 76 minutes of intra-service time and 135 minutes of total time) and determined that the surveyed code appropriately falls between these services based on the physician work and time required to perform these services. Being that the surveyed code is a bilateral procedure for a patient with abnormal connections, there is increased intra-service, in addition to a greater intensity of physician work required. Therefore, the RUC determined that a higher work RVU would be appropriate relative to the other codes in this family. This valuation is consistent with the supporting key reference codes and comparable to the median from the survey results.

For additional support, the RUC referenced CPT code 33745 *Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt* (work RVU= 20.00, 92 minutes intra-service time, and 207 minutes of total time). The RUC reviewed the differences in intra-service time and intensity of physician work and determined that the total time required to perform this service and the longer skin-to-skin time warrant a similar RVU. **Therefore, the RUC recommends a work RVU of 20.00 for CPT code 33903.**

33904 ***Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections (list separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends the survey median work RVU of 7.27 for CPT code 33904. The RUC recommends 45 minutes of intra-service for each additional stent. It is important to note that the work of this procedure is supplementary to the work related to the primary services from this code family and should be used for the additional work related to stent placement of each additional vessel or separate lesion (normal or abnormal) of percutaneous pulmonary artery revascularization.

To justify the value of 7.27, the RUC compared the surveyed code to CPT code 33746 *Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)* (work RVU= 8.00 and 60 minutes of intra-service time/total time) and determined that the surveyed code appropriately relates to this service based on the intensity of physician work and intra-service time required to perform these services.

For additional support, the RUC referenced CPT code 93592 *Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)* (work RVU= 8.00 and 60 minutes of intra-service time). The RUC recognized similarities in the intensity of physician work for these services despite differences in intra-service time; ultimately, this comparison was determined to be in line with the survey results and supports the proposed work RVU. **The RUC recommends a work RVU of 7.27 for CPT code 33904.**

Practice Expense
No direct practice expense inputs are recommended for CPT codes 33900-33904 as they are facility-only services.

New Technology/New Service
The RUC recommends that CPT codes 33900-33904 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Cardiovascular System** **Heart and Pericardium** ***Endovascular Repair of Congenital Heart and Vascular Defects*** *Codes 33894, 33895, 33897 describe transcatheter interventions for revascularization or repair for coarctation of the aorta. Code 33897 describes dilation of the coarctation using balloon angioplasty without stent placement. Codes 33894, 33895 describe stent placement to treat the coarctation. The procedure described in 33894 involves stent placement across one or more major side branches of the aorta. For reporting purposes, the major side branches of the thoracic aorta are the brachiocephalic, carotid, and subclavian arteries, and the major side branches of the abdominal aorta are the celiac, superior mesenteric, inferior mesenteric, and renal arteries.* *Codes 33894, 33895, 33897 include all fluoroscopic guidance of the intervention, diagnostic congenital left heart catheterization, all catheter and wire introductions and manipulation, and angiography of the target lesion.* *Codes 33894, 33895 include stent introduction, manipulation, positioning, and deployment, temporary pacemaker insertion for rapid pacing (33210) to facilitate stent positioning when performed, as well as any additional stent delivery in tandem with the initial stent for extension purposes. Balloon angioplasty within the target treatment zone, either before or after stent deployment, is not separately reportable. For balloon angioplasty of an additional coarctation of the aorta in a segment separate from the treatment zone for the coarctation stent, use 33897.* *For balloon angioplasty of the aorta for lesions other than coarctation (eg, atherosclerosis) of the aorta in a segment separate from the coarctation treatment zone, use 37246.* *For additional diagnostic right heart catheterization in the same setting as 33894, 33895, see 93593, 93594.* *Other interventional procedures performed at the time of endovascular repair of coarctation of the aorta (33894, 33895) may be separately reported (eg, innominate, carotid, subclavian, visceral, iliac, or pulmonary artery balloon angioplasty or stenting, arterial or venous embolization), when performed before or after coarctation stent deployment.*				

33894 *Endovascular stent repair of coarctation of the ascending, transverse, or descending thoracic or abdominal aorta, involving stent placement; across major side branches*

33895 *not crossing major side branches*

(Do not report 33894, 33895 in conjunction with 33210, 34701, 34702, 34703, 34704, 34705, 34706, 36200, 75600, 75605, 75625, 93567, 93595, 93596, 93597)

(Do not report 33894, 33895 in conjunction with 37246, 37236, 33897 for balloon angioplasty of the aorta within the coarctation stent treatment zone)

(For additional atrial, ventricular, pulmonary, coronary or bypass graft angiography in the same setting, see 93563, 93564, 93565, 93566, 93568)

(For angiography of other vascular structures, use the appropriate code from the Radiology/Diagnostic Radiology section)

(For additional congenital right heart catheterization at same setting as 33894, 33895, see 93593, 93594)

33897 *Percutaneous transluminal angioplasty of native or recurrent coarctation of the aorta*

(Do not report 33897 in conjunction with 33210, 34701, 34702, 34703, 34704, 34705, 34706, 36200, 37236, 37246, 75600, 75605, 75625, 93567, 93595, 93596, 93597)

(Do not report 33897 in conjunction with 33894, 33895 for balloon angioplasty of the aorta within the coarctation stent treatment zone)

(For additional congenital right heart diagnostic catheterization performed in same setting as 33897, see 93593, 93594)

(For angioplasty and other transcatheter revascularization interventions of additional upper or lower extremity vessels in same setting, use the appropriate code from the Surgery/Cardiovascular System section)

Codes 33900, 33901, 33902, 33903, 33904 describe endovascular repair of pulmonary artery stenosis by stent placement. Codes 33900, 33901 describe stent placement within the pulmonary arteries via normal native connections, defined as superior vena cava/inferior vena cava to right atrium, then right ventricle, then pulmonary arteries. Codes 33902, 33903 describe stent placement within the pulmonary arteries, ductus arteriosus, or within a surgical shunt, via abnormal connections or through post-surgical shunts (eg, Blalock-Taussig shunt, Sano shunt, or post Glenn or Fontan procedures). Code 33904 is an add-on code that describes placement of stent(s) in additional vessels or lesions beyond the primary vessel or lesion treated whether access is via normal or abnormal connection.

Codes 33900, 33901, 33902, 33903, 33904 include vascular access and all catheter and guidewire manipulation, fluoroscopy to guide the intervention, any post diagnostic angiography for road mapping purposes, and post implant evaluation, stent positioning and balloon inflation for stent delivery, and radiologic supervision and interpretation of the intervention. Angiography at the same session, as part of a diagnostic cardiac catheterization, may be reported with the appropriate angiographic codes from the Radiology or Medicine/Cardiovascular/Cardiac Catheterization/Injection Procedures sections.

Diagnostic cardiac catheterization and diagnostic angiography codes (93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93566, 93567, 93568, *93593, 93594, 93596, 93597, 93598*) should **not** be used with 33900, 33901, 33902, 33903, 33904 to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TPVI,
2. Pulmonary conduit angiography for guidance of TPVI, or
3. Right heart catheterization for hemodynamic measurements before, during, and after TPVI for guidance of TPVI.

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, *93593, 93594, 93595, 93596, 93597, 93598*), diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564), and diagnostic angiography codes 93565, 93566, 93567, 93568 may be separately reported in conjunction with 33900, 33901, 33902, 33903, 33904, representing separate and distinct services from pulmonary artery revascularization, if:

1. No prior study is available and a full diagnostic study is performed, or
2. A prior study is available, but as documented in the medical record:
    a. There is inadequate visualization of the anatomy and/or pathology, or
    b. The patient's condition with respect to the clinical indication has changed since the prior study, or
    c. There is a clinical change during the procedure that requires new evaluation.

Do not report 33900, 33901, 33902, 33903, 33904, in conjunction with 76000, 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, *93593, 93594, 93596, 93597, 93598*, 93563, 93564, 93565, 93566, 93567, 93568 for catheterization and angiography services intrinsic to the procedure.

Balloon angioplasty (92997, 92998) within the same target lesion as stent implant, either before or after stent deployment, is not separately reported.

For balloon angioplasty at the same session as 33900, 33901, 33902, 33903, 33904, but for a distinct lesion or in a different artery, see 92997, 92998.

~~For diagnostic congenital cardiac catheterization performed in conjunction with 33900, 33901, 33902, 33903, 33904, see *93593, 93594, 93595, 93596, 93597.*~~

To report percutaneous pulmonary artery revascularization by stent placement ~~(33900, 33901, 33902, 33903, 33904)~~ in conjunction with diagnostic congenital cardiac catheterization, see 33900, 33901, 33902, 33903, 33904 ~~*93593, 93594, 93595, 93596, 93597*~~.

For transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, see 33745, 33746.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
●33900	A1	Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral	000	14.00
●33901	A2	normal native connections, bilateral	000	18.00
●33902	A3	abnormal connections, unilateral	000	17.33
●33903	A4	abnormal connections, bilateral	000	20.00
✚●33904	A5	Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections (List separately in addition to code for primary procedure) (Use 33904 in conjunction with 33900, 33901, 33902, 33903)	ZZZ	7.27

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33900 Tracking Number A1 Original Specialty Recommended RVU: **14.00**
Presented Recommended RVU: **14.00**
Global Period: 000 Current Work RVU: **NA** RUC Recommended RVU: **14.00**

CPT Descriptor: Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 2-year-old female with prior surgical repair of tetralogy of fallot repair in infancy is suspected to have left pulmonary artery stenosis by echocardiography and physical exam. Congenital diagnostic cardiac catheterization demonstrates severe left pulmonary artery stenosis.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT or MRI, or any other pertinent studies. Based on available information, determine all potential components required for the procedure plus contingencies and backups. Perform and document a complete and/or interval history and physical exam. Provide a description of the procedure and expected results to the parents of the patient, a description of potential risks, and obtain signature of informed consent for the procedure. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Don surgical scrubs & lead. Position patient. Prep, scrub, drape and wait. Perform a "time-out."

Description of Intra-Service Work: The procedure is conducted under general anesthesia using fluoroscopic guidance throughout. Lidocaine is injected to the access sites as an adjunct to general anesthesia. Vascular access is obtained percutaneously, typically in a large vein. The site of venous access may vary due to patient anatomy and vascular access limitations. Arterial access is obtained for hemodynamics and pressure monitoring during intervention. Introducer sheaths are initially placed over a wire in the vein and artery to establish secure access. The wires and dilators are removed, and the sheaths flushed with heparinized saline. Intravenous heparin is administered to achieve therapeutic anticoagulation. The activated clotting time is monitored throughout the case, and additional heparin is administered, as needed.

Diagnostic cardiac catheterization (separately reportable, 93593-93597) (STAFF NOTE: CPT codes 93593-93597 were passed at the May 2020 CPT meeting) including hemodynamic and angiographic evaluation is initially performed and demonstrates an indication for further intervention. Measurement of the lesion as well as neighboring healthy vessel are made from the angiograms, which is used for selection of the appropriate balloon and stent sizes. The angiographic catheter is removed and an end-hole catheter with soft guidewire advanced into and beyond the stenotic pulmonary artery. The soft guidewire is replaced with a stiff interventional guidewire to secure a stable position in the distal branch to support the remainder of the intervention. The chosen stent is prepared, mounted and hand-crimped on the appropriate delivery balloon, which has been de-aired to ensure the lowest possible profile. The diagnostic introducer sheath in the vein is removed and exchanged for a larger and longer sheath to accommodate delivery of the balloon-mounted stent. The delivery sheath is advanced over the wire to the target location, just distal to the lesion in the pulmonary artery. The dilator is removed, and the sheath allowed to bleed back to ensure evacuation of any air, then flushed with heparinized saline. The balloon with mounted stent is loaded onto the wire and advanced through the long sheath to the tip of the sheath. The entire

system is adjusted to position the stent, still within the sheath, across the lesion. Once in the appropriate location, the sheath is carefully withdrawn partially. An angiogram is performed through the side port of the sheath to evaluate the position. Adjustments are made as needed, and angiography repeated until the position is appropriate. The sheath is then withdrawn further, fully exposing the delivery balloon. The balloon is inflated to deliver the stent within the pulmonary artery. The balloon is deflated and removed, maintaining wire position. A larger or higher-pressure balloon catheter may be used to post-dilate the stent to the desired diameter and is not additionally reportable. The balloon is exchanged for a diagnostic catheter to perform hemodynamic assessment of the result. Angiography is also performed to assess the positioning of the delivered stent and potential need for additional intervention. All catheters and sheaths are removed and manual compression or a vascular closure device is used to achieve hemostasis prior to transfer to the recovery area.

Description of Post-Service Work: Following catheterization, an immediate post-procedure note is documented in the medical record. Once hemostasis of the catheterization vascular access sites has been ensured, the patient is transported to the appropriate recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A detailed report is documented which includes an anatomically correct diagram of the congenital heart defects, detailed description of the procedure performed, calculations and interpretation of all the hemodynamic data obtained, review and radiologic interpretation of the angiograms, a complete listing and discussion of the findings, and recommendations based on all of the findings. All necessary data is then also entered into the appropriate national registry, as available/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and review discharge and follow up instructions prior to discharge. For outpatients, stent implantation will typically require an overnight hospital stay and follow-up testing the next morning, which will be reviewed by the operator. For inpatients, communication/hand-off of the findings is made with the intensive care team, as may be appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Mark Hoyer, Edward Toggart, Afnan Tariq, Richard Wright, Thad Waites, Edward Tuohy					
Specialty Society(ies):	Society for Cardiovascular Angiography and Interventions, American College of Cardiology					
CPT Code:	33900					
Sample Size:	363	**Resp N:**	35			
Description of Sample:	SCAI performed a random survey of 209 Pediatric Interventional Cardiologist and ACC performed a random survey of 163 Pediatric Interventional Cardiologists					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	8.00	**12.00**	20.00	75.00
Survey RVW:	8.00	11.03	**14.00**	18.00	23.57
Pre-Service Evaluation Time:			**62.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	20.00	60.00	**90.00**	118.00	200.00

Immediate Post Service-Time:	**45.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33900	**Recommended Physician Work RVU: 14.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**6.00**	**3.00**	**3.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**90.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**45.00**	**33.00**	**12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92928	000	10.96	**RUC Time**

CPT Descriptor Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33340	000	14.00	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 34.2 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 25.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 33900	Top Key Reference CPT Code: 92928	2nd Key Reference CPT Code: **93580**
Median Pre-Service Time	71.00	29.00	30.00
Median Intra-Service Time	90.00	76.00	120.00
Median Immediate Post-service Time	45.00	30.00	60.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**206.00**	**135.00**	**210.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	67%	25%	8%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	75%	17%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	58%	42%
Physical effort required	0%	42%	58%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	42%	25%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	100%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	22%	78%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	11%	89%
Physical effort required	0%	11%	89%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	11%	89%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel approved a new family of five codes at the February Panel meeting describing physician services to describe pulmonary artery stenting after a long shift toward percutaneous endovascular approaches in some patients. While initially balloon angioplasty was the only possible treatment for pulmonary artery stenosis (PAS), particularly for small children, the use of endovascular stents has developed and improved outcomes versus angioplasty alone. Compared

to other peripheral vascular angioplasty and stenting interventions, the work performed in the pulmonary arteries poses greater complexity and risk not captured by other existing peripheral vascular CPT codes. Additionally, there is currently no way in CPT to track patients undergoing endovascular repair of PAS due to the large number of patients treated for other pathologies with any of the existing codes that are used to report this work.

CPT codes 33900-33904 are for endovascular repair of pulmonary artery stenosis by stent placement. Codes 33900 and 33901 are for stent placement within the pulmonary arteries via normal native connections, defined as venous access through normal right heart structures and chambers. Codes 33902 and 33903 are for stent placement within the pulmonary arteries, ductus arteriosus, or within a surgical shunt, via abnormal connections or through post-surgical shunts (eg, Blalock-Taussig shunt, Sano shunt, or post Glenn or Fontan procedures). Code 33904 is for each additional stent placed at any location via normal or abnormal connections. Due to the extreme variability of the underlying diagnosis associated with pulmonary artery stenosis, it is impossible to determine if a right heart only, left heart only, or combined right and left diagnostic study is needed. Therefore, congenital diagnostic cardiac catheterization is separately reportable with CPT codes 93593-93597.

Survey of the codes was deferred one meeting while some introductory coding language was revised by the Panel in consultation with the specialties. Specialty societies randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service.

As we move through this family of codes, there are three relationships in which we anticipate the RUC will be interested. The first is an increase in time and work as the codes move from unilateral to bilateral. That relationship exists and appears appropriate to the expert panel, with increased time and work for bilateral procedures. The second is an increase in work as the codes move from “normal native” connections to “abnormal” connections. That relationship also exists and appears appropriate to the expert panel. The final relationship that one might expect to see but does not exist is an increase in time as the codes move from “normal native” connections to “abnormal” connections. We can speak to this in greater detail during discussion of the abnormal codes at the meeting, but will explain here that while the times may be the same, the increased work can be attributed to increased intensity of these services in patients with abnormal connections: interpretations of any other angiographic studies are more difficult; operators are looking for additional lesions throughout the procedure, whereas in a healthy child with normal connections that complexity doesn’t exist; this essentially creates more complex MDM throughout procedure, as the operator is constantly thinking about what else could be wrong.

Finally, we note a logical progression in WPUT throughout the family as we progress from unilateral stenting in normal native connections to bilateral stenting in abnormal connections, from 0.068 to 0.076 to 0.083 and 0.083, respectively, that we suggest supports the time and RVU recommendations.

Preservice/Postservice

The societies have sought, and the RUC has approved additional time in similar circumstances at several recent meetings, with additional time most commonly added for review of records/imaging, extended discussions with family/parents, additional positioning, additional wound dressing, prolonged monitoring, and extensive documentation (eg. anatomically correct diagram with hemodynamic data embedded). Those elements apply with this family of codes, and we describe recommendations beyond traditional standards here.

Separately at this meeting, the societies submitted information requesting a degree of standardization for additional time in the preservice and postservice periods to reflect complicating factors physicians face when treating patients in need of complex congenital cardiac procedures. The Research Subcommittee opted not to pursue a standardized addition, but rather to consider requests for additional time for complex congenital cardiac procedures on an ad hoc basis when each code is presented. Insofar as surveys supported times beyond the standards in Preservice Package 4 and Postservice Package 9B, we have made recommendations for additional preservice and postservice time consistent with that submission.

For 33900 that results in a recommendation for 10 additional minutes of evaluation time—with 5 additional minutes for procedure preparation, 3 additional minutes for communication/consent with patient/family, and 2 additional minutes to prepare/gown/drape the patient. This produces a recommendation of 50 minutes preservice evaluation time rather than 40. Survey respondents indicated 62 minutes at the median.

> *“Prepare for Procedure (Check labs, plan, assess risks, review procedure)”:* Time to prepare for the procedure is considerable. The typical patient has extensive past cardiac history. It is vital to review their past cardiac

catheterization reports, angiographic imaging, any existing CT or cardiac MR, and prior surgical history. Previous percutaneous access issues must also be reviewed including from prior cardiac catheterization procedures or long standing CVL placement during ICU care.

"Communicate with patient and/or family (Discuss procedure/ obtain consent)": The time to discuss a patient's procedure with the parent of a child is greater than the typical discussions when an adult patient consents for themselves. This leads to considerably more time for explaining the procedure and consenting the family for the forthcoming procedure.

"Check/ prepare patient readiness (Gown, drape, prep, mark)": Whereas anxiolytic medications are quite often administered to alleviate patient anxiety in a typical pre-operative setting, this is not typical in cardiac patients due to concerns about hemodynamic instability. Therefore, parents are relied upon for significant patient coaching and may even accompany the child to the catheterization lab, where they spend 1-2 minutes comforting the child as the anesthesiologist administers inhalational sedation in a controlled setting.

We recommend 3 additional minutes for positioning, for a total 6 minutes. Survey respondents indicated 15 minutes at the median.

"Perform/ supervise patient positioning": Positioning of these patients is more time consuming. Positioning is complicated by the requirement for bi-plane fluoroscopic equipment. Given the extensive intra-procedure monitoring that is necessary, the myriad of EKG wires (2 sets), IV tubing, pH probe, etc. must be precisely positioned so as not to be in the way of either of the bi-plane imaging views. Patients are then positioned with both arms extended above the head and the legs pigeon toed and secured in this position for femoral access. It is also common to obtain access from both the groin and the neck during the same procedure, which means three points of access (bilateral femoral and right neck) must be prepped and draped in sterile fashion. Additional positioning occurs to move the arm(s) up when operators prefer arms down to obtain neck access. Arm positioning is particularly important for anticipated long procedures to avoid brachial plexus injury. All of this must be done while maintaining a sterile environment.

For postservice time, we recommend 12 additional minutes, consistent with the survey median time of 45 minutes. This would be comprised of 2 additional minutes for application of dressing, 3 additional minutes for monitoring/stabilization, 3 additional minutes communication with patient/family, and 4 additional minutes for the written post-op note.

"Application of dressing": As noted in the description of the post-service package breakdown, the existing times allow for a "simple dressing". Unlike adult catheterization patients, who typically have closure devices placed as part of the intra-procedure time, these devices are not typically used in children, and various dressings are applied instead. Pressure dressings are the most common, but other sites may require additional occlusive dressings (eg. Opsite, Tegaderm) prior to pressure dressing application or by themselves. Patients in the congenital cardiac surgical suite will have dressings applied to multiple sites, including mediastinal and pleural drains, as well as a sternal dressing, which often involves an open sternum.

"Monitor patient recovery/stabilization": Due to the labile hemodynamics most of these patients demonstrate, a prolonged period for monitoring is needed immediately upon completion of the case. This provides additional time for emerging from sedation/anesthesia to prevent dramatic swings in systemic and/or pulmonary vascular resistance.

"Communication with patient and/or family": As explained in the pre-service package for the same issue, communication of complex cardiac findings and interventions is more time consuming for the family of a child as compared to an adult patient with other pathologies. Additionally, the discussion typically extends into explanation of next steps, namely whether or not there is need for complex surgery or medical management.

"Written Post-operative Note": In addition to the traditional immediate post-operative note (a separate line item) a comprehensive post-operative report is documented for these patients. Unlike the typical post procedure report of other specialties for which the existing post procedure package includes 5 minutes, these reports incorporate multiple additional elements including:

a. A list of prior relevant cardiac surgical procedures and the indications for the current procedure;

b. A detailed operative procedure report including all catheter and wire manipulations necessary to catheterize particularly difficult vessels and/or chambers;
c. Summary discussion of the hemodynamic findings including calculations of cardiac index, systemic and pulmonary vascular resistance, and any intra-cardiac shunt fractions;
d. Safe hand-off/communication is made with the hospital rounding team for inpatients returning to their respective units;
e. A complete radiologic report describing all of the findings from the angiograms performed;
f. An anatomically accurate drawing of the cardiac defect(s) is performed, usually using existing software programs (a time-consuming effort that facilitates understanding for all providers); and
g. All data obtained must be duplicated and entered into a national registry, such as IMPACT

33900

Code 33900 is the first code in the family and describes the work of unilateral pulmonary artery stent placement in a heart with normal native connections. The key reference code is 92928 for percutaneous coronary stenting. It was selected by 34% of respondents. 67% of the respondents indicated that 33900 was of identical complexity, while the rest indicated it was more complex. The second reference code is 93580 for percutaneous transcatheter closure of a congenital interatrial communication. It was selected by 26% of respondents. 100% of the respondents indicated that 33900 was more intense/complex overall.

Recommendation

Therefore, for code 33900 the **societies recommend the survey median RVW of 14.00 with 71 minutes preservice time, 90 minutes intraservice time from the survey median, and 45 minutes postservice time**. This fits between the times and work RVUs of theintensity of the KRS, which survey respondents felt was similarly intense to 33900, and also compares well to MPC code 37244 for vascular embolization of a hemorrhage and code 33340 for percutaneous closure of the left atrial appendage, both in terms of time and work RVU, as shown in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. NA

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Interventional Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. CCA estimate

Specialty Pediatric/Interventional Cardiology Frequency 600 Percentage 60.00 %

Specialty Cardiology Frequency 400 Percentage 40.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is possible that a very small percentage of patients may be beneficiaries

Specialty Pediatric/Interventional Cardiology Frequency 20 Percentage 50.00 %

Specialty Cardiology Frequency 20 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93530

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33901 Tracking Number A2 Original Specialty Recommended RVU: **18.00**
Presented Recommended RVU: **18.00**
Global Period: 000 Current Work RVU: **NA** RUC Recommended RVU: **18.00**

CPT Descriptor: Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, bilateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 4-year-old male with history of extreme prematurity, chronic lung disease, and tracheostomy is found to have right ventricular hypertension by echocardiography, and bilateral pulmonary artery stenosis on mri. congenital diagnostic cardiac catheterization demonstrates severe bilateral pulmonary artery stenosis.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT or MRI, or any other pertinent studies. Based on available information, determine all potential components required for the procedure plus contingencies and backups. Perform and document a complete and/or interval history and physical exam. Provide a description of the procedure and expected results to the parents of the patient, a description of potential risks, and obtain signature of informed consent for the procedure. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Don surgical scrubs & lead. Position patient. Prep, scrub, drape and wait. Perform a “time-out.”

Description of Intra-Service Work: The procedure is conducted under general anesthesia using fluoroscopic guidance throughout. Lidocaine is injected to the access sites as an adjunct to general anesthesia. Vascular access is obtained percutaneously, typically in a large vein. The site of venous access may vary due to patient anatomy and any vascular access limitations. Arterial access is typically obtained for hemodynamics and pressure monitoring during intervention. Introducer sheaths are initially placed over a wire in the vein and artery to establish secure access. The wires and dilators are removed, and the sheaths flushed with heparinized saline. Intravenous heparin is administered to achieve therapeutic anticoagulation. The activated clotting time is monitored throughout the case, and additional heparin is administered, as needed.

Diagnostic cardiac catheterization (separately reportable, 93593-97) including hemodynamic and angiographic evaluation is initially performed and demonstrates an indication for further intervention. After identification of bilateral right and left main pulmonary artery stenosis, measurements of the lesions as well as neighboring healthy vessels are made from the angiograms, which are used for selection of the appropriate balloon and stent sizes. The angiographic catheter is removed and an end-hole catheter with soft guidewire advanced into and beyond the stenotic pulmonary artery and extended into the distal right lower lobe branch. The soft guidewire is replaced with a stiff interventional guidewire to secure a stable position in the distal branch to support the remainder of the intervention. The chosen stent is prepared, mounted and hand-crimped on the appropriate delivery balloon, which has been de-aired to ensure the lowest possible profile. The diagnostic introducer sheath in the vein is removed and exchanged for a larger and longer sheath to accommodate delivery of the balloon-mounted stent. The delivery sheath is advanced over the wire to the target location, just distal to the lesion in the right pulmonary artery. The dilator is removed, and the sheath allowed to bleed back to ensure evacuation of any air, then

flushed with heparinized saline. The balloon-mounted stent is loaded onto the wire and advanced through the long sheath to the tip of the sheath. The entire system is adjusted to position the stent, still within the sheath, across the lesion. Once in the appropriate location, the sheath is carefully withdrawn partially. An angiogram is performed through the side port of the sheath to evaluate the position. Adjustments are made, as needed and angiography repeated until the position is appropriate. The sheath is then withdrawn further, fully exposing the delivery balloon. The balloon is inflated to deliver the stent within the pulmonary artery. The balloon is deflated and removed, maintaining wire position. A larger or higher-pressure balloon catheter may be used to post-dilate the stent to the desired diameter and is not additionally reportable. The balloon is exchanged for a diagnostic catheter to perform hemodynamic assessment of the result. Angiography is also performed to assess the positioning of the delivered stent and potential need for additional intervention. The diagnostic catheter is then inserted and used to retrieve the stiff interventional wire and remove it from the body. The soft tipped guidewire is then re-inserted through the catheter and advanced into and beyond the stenotic left pulmonary artery and extended into the distal left lower lobe branch. Once again, the guidewire is removed and the stiff interventional wire re-inserted to secure left sided wire position for the subsequent intervention. The entire process described above for the right sided stent is now repeated to address the left pulmonary artery stenosis. Once the left sided lesion is successfully stented, a final main pulmonary artery angiogram is repeated to assess the final results of the bilateral stent implants.

All catheters and sheaths are removed and manual compression or a vascular closure device is used to achieve hemostasis prior to transfer to the recovery area.

Description of Post-Service Work: Following catheterization, an immediate post-procedure note is documented in the medical record. Once hemostasis of the catheterization vascular access sites has been ensured, the patient is transported to the appropriate recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A detailed report is documented which includes an anatomically correct diagram of the congenital heart defects, detailed description of the procedure performed, calculations and interpretation of all the hemodynamic data obtained, review and radiologic interpretation of the angiograms, a complete listing and discussion of the findings, and recommendations based on all of the findings. All necessary data is then also entered into the appropriate national registry, as available/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and review discharge and follow up instructions prior to discharge. For outpatients, stent implantation will typically require an overnight hospital stay and follow-up testing the next morning, which will be reviewed by the operator. For inpatients, communication/hand-off of the findings is made with the intensive care team, as may be appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Mark Hoyer, Edward Toggart, Afnan Tariq, Richard Wright, Thad Waites, Edward Tuohy					
Specialty Society(ies):	Society for Cardiovascular Angiography and Interventions, American College of Cardiology					
CPT Code:	33901					
Sample Size:	363	**Resp N:**	35			
Description of Sample:	SCAI performed a random survey of 209 Pediatric Interventional Cardiologists and ACC performed a random survey of 163 Pediatric Interventional Cardiologists					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	2.00	**5.00**	8.00	50.00
Survey RVW:		10.00	14.50	**18.00**	22.05	26.70
Pre-Service Evaluation Time:				**67.00**		
Pre-Service Positioning Time:				**15.00**		
Pre-Service Scrub, Dress, Wait Time:				**15.00**		
Intra-Service Time:		35.00	90.00	**120.00**	160.00	250.00
Immediate Post Service-Time:	**45.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33901	**Recommended Physician Work RVU: 18.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**6.00**	**3.00**	**3.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**45.00**	**33.00**	**12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93580	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of congenital interatrial communication (ie, Fontan fenestration, atrial septal defect) with implant

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92928	000	10.96	**RUC Time**

CPT Descriptor Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
93591	000	17.97	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, aortic valve

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 25.7 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 22.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 33901	Top Key Reference CPT Code: 93580	2nd Key Reference CPT Code: 92928
Median Pre-Service Time	71.00	30.00	29.00
Median Intra-Service Time	120.00	120.00	76.00
Median Immediate Post-service Time	45.00	60.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**236.00**	**210.00**	**135.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	67%	33%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	0%	100%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	11%	89%
Physical effort required	0%	11%	89%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	11%	89%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	25%	50%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	25%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	38%	62%
Physical effort required	0%	38%	62%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	12%	38%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel approved a new family of five codes at the February Panel meeting describing physician services to describe pulmonary artery stenting after a long shift toward percutaneous endovascular approaches in some patients. While initially balloon angioplasty was the only possible treatment for pulmonary artery stenosis (PAS), particularly for small children, the use of endovascular stents has developed and improved outcomes versus angioplasty alone. Compared

to other peripheral vascular angioplasty and stenting interventions, the work performed in the pulmonary arteries poses greater complexity and risk not captured by other existing peripheral vascular CPT codes. Additionally, there is currently no way in CPT to track patients undergoing endovascular repair of PAS due to the large number of patients treated for other pathologies with any of the existing codes that are used to report this work.

CPT codes 33900-33904 are for endovascular repair of pulmonary artery stenosis by stent placement. Codes 33900 and 33901 are for stent placement within the pulmonary arteries via normal native connections, defined as venous access through normal right heart structures and chambers. Codes 33902 and 33903 are for stent placement within the pulmonary arteries, ductus arteriosus, or within a surgical shunt, via abnormal connections or through post-surgical shunts (eg, Blalock-Taussig shunt, Sano shunt, or post Glenn or Fontan procedures). Code 33904 is for each additional stent placed at any location via normal or abnormal connections. Due to the extreme variability of the underlying diagnosis associated with pulmonary artery stenosis, it is impossible to determine if a right heart only, left heart only, or combined right and left diagnostic study is needed. Therefore, congenital diagnostic cardiac catheterization is separately reportable with CPT codes 93593-93597.

Survey of the codes was deferred one meeting while some introductory coding language was revised by the Panel in consultation with the specialties. Specialty societies randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service.

As we move through this family of codes, there are three relationships in which we anticipate the RUC will be interested. The first is an increase in time and work as the codes move from unilateral to bilateral. That relationship exists and appears appropriate to the expert panel, with increased time and work for bilateral procedures. The second is an increase in work as the codes move from “normal native” connections to “abnormal” connections. That relationship also exists and appears appropriate to the expert panel. The final relationship that one might expect to see but does not exist is an increase in time as the codes move from “normal native” connections to “abnormal” connections. We can speak to this in greater detail during discussion of the abnormal codes at the meeting, but will explain here that while the times may be the same, the increased work can be attributed to increased intensity of these services in patients with abnormal connections: interpretations of any other angiographic studies are more difficult; operators are looking for additional lesions throughout the procedure, whereas in a healthy child with normal connections that complexity doesn’t exist; this essentially creates more complex MDM throughout procedure, as the operator is constantly thinking about what else could be wrong.

Finally, we note a logical progression in WPUT throughout the family as we progress from unilateral stenting in normal native connections to bilateral stenting in abnormal connections, from 0.068 to 0.076 to 0.083 and 0.083, respectively, that we suggest supports the time and RVU recommendations.

Preservice/Postservice

The societies have sought, and the RUC has approved additional time in similar circumstances at several recent meetings, with additional time most commonly added for review of records/imaging, extended discussions with family/parents, additional positioning, additional wound dressing, prolonged monitoring, and extensive documentation (eg. anatomically correct diagram with hemodynamic data embedded). Those elements apply with this family of codes, and we describe recommendations beyond traditional standards here.

Separately at this meeting, the societies submitted information requesting a degree of standardization for additional time in the preservice and postservice periods to reflect complicating factors physicians face when treating patients in need of complex congenital cardiac procedures. The Research Subcommittee opted not to pursue a standardized addition, but rather to consider requests for additional time for complex congenital cardiac procedures on an ad hoc basis when each code is presented. Insofar as surveys supported times beyond the standards in Preservice Package 4 and Postservice Package 9B, we have made recommendations for additional preservice and postservice time consistent with that submission.

For 33901 that results in a recommendation for 10 additional minutes of evaluation time—with 5 additional minutes for prepare for the procedure, 3 additional minutes for communication/consent with patient/family, and 2 additional minutes to prepare/gown/drape the patient. This produces a recommendation of 50 minutes preservice evaluation time rather than 40. Survey respondents indicated 62 minutes at the median.

> *“Prepare for Procedure (Check labs, plan, assess risks, review procedure)”:* Time to prepare for the procedure is considerable. The typical patient has extensive past cardiac history. It is vital to review their past cardiac

catheterization reports, angiographic imaging, any existing CT or cardiac MR, and prior surgical history. Previous percutaneous access issues must also be reviewed including from prior cardiac catheterization procedures or long standing CVL placement during ICU care.

"Communicate with patient and/or family (Discuss procedure/ obtain consent)": The time to discuss a patient's procedure with the parent of a child is greater than the typical discussions when an adult patient consents for themselves. This leads to considerably more time for explaining the procedure and consenting the family for the forthcoming procedure.

"Check/ prepare patient readiness (Gown, drape, prep, mark)": Whereas anxiolytic medications are quite often administered to alleviate patient anxiety in a typical pre-operative setting, this is not typical in cardiac patients due to concerns about hemodynamic instability. Therefore, parents are relied upon for significant patient coaching and may even accompany the child to the catheterization lab, where they spend 1-2 minutes comforting the child as the anesthesiologist administers inhalational sedation in a controlled setting.

We recommend 3 additional minutes for positioning, for a total 6 minutes. Survey respondents indicated 15 minutes at the median.

"Perform/ supervise patient positioning": Positioning of these patients is more time consuming. Positioning is complicated by the requirement for bi-plane fluoroscopic equipment. Given the extensive intra-procedure monitoring that is necessary, the myriad of EKG wires (2 sets), IV tubing, pH probe, etc. must be precisely positioned so as not to be in the way of either of the bi-plane imaging views. Patients are then positioned with both arms extended above the head and the legs pigeon toed and secured in this position for femoral access. It is also common to obtain access from both the groin and the neck during the same procedure, which means three points of access (bilateral femoral and right neck) must be prepped and draped in sterile fashion. Additional positioning occurs to move the arm(s) up when operators prefer arms down to obtain neck access. Arm positioning is particularly important for anticipated long procedures to avoid brachial plexus injury. All of this must be done while maintaining a sterile environment.

For postservice time, we recommend 12 additional minutes, consistent with the survey median time of 45 minutes. This would be comprised of 2 additional minutes for application of dressing, 3 additional minutes for monitoring/stabilization, 3 additional minutes communication with patient/family, and 4 additional minutes for the written post-op note.

"Application of dressing": As noted in the description of the post-service package breakdown, the existing times allow for a "simple dressing". Unlike adult catheterization patients, who typically have closure devices placed as part of the intra-procedure time, these devices are not typically used in children, and various dressings are applied instead. Pressure dressings are the most common, but other sites may require additional occlusive dressings (eg. Opsite, Tegaderm) prior to pressure dressing application or by themselves. Patients in the congenital cardiac surgical suite will have dressings applied to multiple sites, including mediastinal and pleural drains, as well as a sternal dressing, which often involves an open sternum.

"Monitor patient recovery/stabilization": Due to the labile hemodynamics most of these patients demonstrate, a prolonged period for monitoring is needed immediately upon completion of the case. This provides additional time for emerging from sedation/anesthesia to prevent dramatic swings in systemic and/or pulmonary vascular resistance.

"Communication with patient and/or family": As explained in the pre-service package for the same issue, communication of complex cardiac findings and interventions is more time consuming for the family of a child as compared to an adult patient with other pathologies. Additionally, the discussion typically extends into explanation of next steps, namely whether or not there is need for complex surgery or medical management.

"Written Post-operative Note": In addition to the traditional immediate post-operative note (a separate line item) a comprehensive post-operative report is documented for these patients. Unlike the typical post procedure report of other specialties for which the existing post procedure package includes 5 minutes, these reports incorporate multiple additional elements including:

a. A list of prior relevant cardiac surgical procedures and the indications for the current procedure;

b. A detailed operative procedure report including all catheter and wire manipulations necessary to catheterize particularly difficult vessels and/or chambers;
c. Summary discussion of the hemodynamic findings including calculations of cardiac index, systemic and pulmonary vascular resistance, and any intra-cardiac shunt fractions;
d. Safe hand-off/communication is made with the hospital rounding team for inpatients returning to their respective units;
e. A complete radiologic report describing all of the findings from the angiograms performed;
f. An anatomically accurate drawing of the cardiac defect(s) is performed, usually using existing software programs (a time-consuming effort that facilitates understanding for all providers); and
g. All data obtained must be duplicated and entered into a national registry, such as IMPACT

33901

Code 33901 is the second code in the family and describes the work of bilateral pulmonary artery stent placement in a heart with normal native connections. The key reference code is 93580 for percutaneous transcatheter closure of a congenital interatrial communication. It was selected by 26% of respondents. 100% of the respondents indicated that 33901 is more intense/complex overall. The second reference code is 92928 for percutaneous coronary stenting. It was selected by 23% of respondents. 75% of these respondents indicated 33901 is more intense/complex overall.

Recommendation

Therefore, for code 33901 the **societies recommend the survey median RVW of 18.00 with 71 minutes preservice time, 120 minutes intraservice time from the survey median, and 45 minutes postservice time**. This aligns reasonably well with the intensity, time, and RVU of the KRS, which survey respondents felt was less intense than 33901. It also compares well to the intensity of MPC code 37244 for vascular embolization of a hemorrhage, and with the intensity, time, and RVU of code 93591 for percutaneous closure of aortic paravalvular leak, as shown in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. NA

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93799

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)

If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Interventional Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate from CCA

Specialty Pediatric/Interventional Cardiology Frequency 300 Percentage 60.00 %

Specialty Cardiology Frequency 200 Percentage 40.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is possible that a very small percentage of patients may be beneficiaries

Specialty Pediatric/Interventional Cardiology Frequency 20 Percentage 50.00 %

Specialty Cardiology Frequency 20 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93530

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33902 Tracking Number 33902 Original Specialty Recommended RVU: **17.33**
Presented Recommended RVU: **17.33**
Global Period: 000 Current Work RVU: **NA** RUC Recommended RVU: **17.33**

CPT Descriptor: Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, unilateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 3-month-old female with pulmonary atresia and intact ventricular septum who underwent surgical blalock-taussig-thomas (btt) shunt in the neonatal period presents with worsening systemic hypoperfusion, shock, and evidence of acute shunt stenosis. she is brought to the cardiac catheterization laboratory emergently for stenting of the btt shunt.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT or MRI, or any other pertinent studies. Based on available information, determine all potential components required for the procedure plus contingencies and backups. Perform and document a complete and/or interval history and physical exam. Provide a description of the procedure and expected results to the parents of the patient, a description of potential risks, and obtain signature of informed consent for the procedure. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Don surgical scrubs & lead. Position patient. Prep, scrub, drape and wait. Perform a “time-out.”

Description of Intra-Service Work: The procedure is conducted under general anesthesia using fluoroscopic guidance throughout. Lidocaine is injected to the access sites to help minimize hypotension caused by excessive general anesthetic. Vascular access is obtained percutaneously, typically in a large vein and an artery. The site of venous access is variable and depends on patient anatomy and any vascular access limitations. Arterial access is typically obtained in a femoral artery but may require carotid artery access. Introducer sheaths are initially placed over a wire in the vein and artery to establish secure access. The wires and dilators are removed, and the sheaths flushed with heparinized saline. Intravenous heparin is administered to achieve therapeutic anticoagulation. The activated clotting time is monitored throughout the case, and additional heparin is administered, as needed.

Diagnostic catheterization varies due to inconsistent venous or arterial access to the pulmonary arteries. Diagnostic cardiac catheterization (separately reportable, 93593-97) including hemodynamic and angiographic evaluation is initially performed and demonstrates an indication for further intervention. If the pulmonary arteries originate from the aorta, the diagnostic evaluation would include an aortogram to evaluate the shunt or ductal pathway to the pulmonary arteries for stenosis. Measurements of the lesion as well as neighboring healthy vessels are made from the angiograms, which are used for selection of the appropriate balloon and stent sizes. The angiographic catheter is removed and an end-hole catheter with soft guidewire advanced into and beyond the stenotic lesion. The soft guidewire is replaced with a stiff interventional guidewire to secure a stable position in the distal branch to support the remainder of the intervention. The chosen stent is prepared, mounted and hand-crimped on the appropriate delivery balloon, which has been de-aired to ensure the lowest possible profile. The diagnostic introducer sheath is removed and exchanged for a larger and longer sheath to accommodate

delivery of the balloon-mounted stent. The delivery sheath is advanced over the wire to the target location, just distal to the lesion. The dilator is removed, and the sheath allowed to bleed back to ensure evacuation of any air, then flushed with heparinized saline. The balloon with mounted stent is loaded onto the wire and advanced through the long sheath to the tip of the sheath. The entire system is adjusted to position the stent, still within the sheath, across the lesion. Once in the appropriate location, the sheath is carefully withdrawn partially. An angiogram is performed through the side port of the sheath to evaluate the position. Adjustments are made, as needed and angiography repeated until the position is appropriate. The sheath is then withdrawn further, fully exposing the delivery balloon. The balloon is inflated to deliver the stent within the target lesion. The balloon is deflated and removed, maintaining wire position. A larger or higher-pressure balloon catheter may be used to post-dilate the stent to the desired diameter and is not additionally reportable. The balloon is exchanged for a diagnostic catheter to perform hemodynamic assessment of the result. Angiography is also performed to assess the positioning of the delivered stent and potential need for additional intervention. All catheters and sheaths are removed and manual compression or a vascular closure device is used to achieve hemostasis prior to transfer to the recovery area.

Description of Post-Service Work: Following catheterization, an immediate post-procedure note is documented in the medical record. Once hemostasis of the catheterization vascular access sites has been ensured, the patient is transported to the appropriate recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A detailed report is documented which includes an anatomically correct diagram of the congenital heart defects, detailed description of the procedure performed, calculations and interpretation of all the hemodynamic data obtained, review and radiologic interpretation of the angiograms, a complete listing and discussion of the findings, and recommendations based on all of the findings. All necessary data is then also entered into the appropriate national registry, as available/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and review discharge and follow up instructions prior to discharge. For outpatients, stent implantation will typically require an overnight hospital stay and follow-up testing the next morning, which will be reviewed by the operator. For inpatients, communication/hand-off of the findings is made with the intensive care team, as may be appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Mark Hoyer, Edward Toggart, Afnan Tariq, Richard Wright, Thad Waites, Edward Tuohy					
Specialty Society(ies):	Society for Cardiovascular Angiography and Interventions, American College of Cardiology					
CPT Code:	33902					
Sample Size:	363	**Resp N:**	34			
Description of Sample:	SCAI performed a random survey of 209 Pediatric Interventional Cardiologists and ACC performed a random survey of 163 Pediatric Interventional Cardiologists					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**7.00**	15.00	75.00
Survey RVW:	8.00	14.00	**17.33**	21.51	26.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	30.00	62.00	**90.00**	129.00	220.00

Immediate Post Service-Time:	**48.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33902	**Recommended Physician Work RVU: 17.33**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**6.00**	**3.00**	**3.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**90.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**48.00**	**33.00**	**15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93590	000	21.70	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leak; initial occlusion device, mitral valve

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37231	000	14.75	**RUC Time**

CPT Descriptor Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement(s) and atherectomy, includes angioplasty within the same vessel, when performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33955	000	16.00	**RUC Time**

CPT Descriptor Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) provided by physician; insertion of central cannula(e) by sternotomy or thoracotomy, birth through 5 years of age

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 23.5 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 17.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 33902	Top Key Reference CPT Code: 93590	2nd Key Reference CPT Code: **37231**
Median Pre-Service Time	71.00	58.00	38.00
Median Intra-Service Time	90.00	135.00	135.00
Median Immediate Post-service Time	48.00	30.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**209.00**	**223.00**	**203.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	38%	50%	12%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	25%	62%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	25%	38%	37%
Physical effort required	25%	38%	62%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	38%	62%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	34%	33%	33%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	77%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	17%	83%
Physical effort required	0%	33%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	17%	83%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel approved a new family of five codes at the February Panel meeting describing physician services to describe pulmonary artery stenting after a long shift toward percutaneous endovascular approaches in some patients. While initially balloon angioplasty was the only possible treatment for pulmonary artery stenosis (PAS), particularly for small children, the use of endovascular stents has developed and improved outcomes versus angioplasty alone. Compared

to other peripheral vascular angioplasty and stenting interventions, the work performed in the pulmonary arteries poses greater complexity and risk not captured by other existing peripheral vascular CPT codes. Additionally, there is currently no way in CPT to track patients undergoing endovascular repair of PAS due to the large number of patients treated for other pathologies with any of the existing codes that are used to report this work.

CPT codes 33900-33904 are for endovascular repair of pulmonary artery stenosis by stent placement. Codes 33900 and 33901 are for stent placement within the pulmonary arteries via normal native connections, defined as venous access through normal right heart structures and chambers. Codes 33902 and 33903 are for stent placement within the pulmonary arteries, ductus arteriosus, or within a surgical shunt, via abnormal connections or through post-surgical shunts (eg, Blalock-Taussig shunt, Sano shunt, or post Glenn or Fontan procedures). Code 33904 is for each additional stent placed at any location via normal or abnormal connections. Due to the extreme variability of the underlying diagnosis associated with pulmonary artery stenosis, it is impossible to determine if a right heart only, left heart only, or combined right and left diagnostic study is needed. Therefore, congenital diagnostic cardiac catheterization is separately reportable with CPT codes 93592-93597.

Survey of the codes was deferred one meeting while some introductory coding language was revised by the Panel in consultation with the specialties. Specialty societies randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service.

As we move through this family of codes, there are three relationships in which we anticipate the RUC will be interested. The first is an increase in time and work as the codes move from unilateral to bilateral. That relationship exists and appears appropriate to the expert panel, with increased time and work for bilateral procedures. The second is an increase in work as the codes move from “normal native” connections to “abnormal” connections. That relationship also exists and appears appropriate to the expert panel. The final relationship that one might expect to see but does not exist is an increase in time as the codes move from “normal native” connections to “abnormal” connections. We can speak to this in greater detail during discussion of the abnormal codes at the meeting, but will explain here that while the times may be the same, the increased work can be attributed to increased intensity of these services in patients with abnormal connections: interpretations of any other angiographic studies are more difficult; operators are looking for additional lesions throughout the procedure, whereas in a healthy child with normal connections that complexity doesn’t exist; this essentially creates more complex MDM throughout procedure, as the operator is constantly thinking about what else could be wrong.

Finally, we note a logical progression in WPUT throughout the family as we progress from unilateral stenting in normal native connections to bilateral stenting in abnormal connections, from 0.068 to 0.076 to 0.083 and 0.083, respectively, that we suggest supports the time and RVU recommendations.

Preservice/Postservice

The societies have sought, and the RUC has approved additional time in similar circumstances at several recent meetings, with additional time most commonly added for review of records/imaging, extended discussions with family/parents, additional positioning, additional wound dressing, prolonged monitoring, and extensive documentation (eg. anatomically correct diagram with hemodynamic data embedded). Those elements apply with this family of codes, and we describe recommendations beyond traditional standards here.

Separately at this meeting, the societies submitted information requesting a degree of standardization for additional time in the preservice and postservice periods to reflect complicating factors physicians face when treating patients in need of complex congenital cardiac procedures. The Research Subcommittee opted not to pursue a standardized addition, but rather to consider requests for additional time for complex congenital cardiac procedures on an ad hoc basis when each code is presented. Insofar as surveys supported times beyond the standards in Preservice Package 4 and Postservice Package 9B, we have made recommendations for additional preservice and postservice time consistent with that submission.

For 33902 that results in a recommendation for 10 additional minutes of evaluation time—with 5 additional minutes for prepare for the procedure, 3 additional minutes for communication/consent with patient/family, and 2 additional minutes to prepare/gown/drape the patient. This produces a recommendation of 50 minutes preservice evaluation time rather than 40. Survey respondents indicated 62 minutes at the median.

> *“Prepare for Procedure (Check labs, plan, assess risks, review procedure)”:* Time to prepare for the procedure is considerable. The typical patient has extensive past cardiac history. It is vital to review their past cardiac

catheterization reports, angiographic imaging, any existing CT or cardiac MR, and prior surgical history. Previous percutaneous access issues must also be reviewed including from prior cardiac catheterization procedures or long standing CVL placement during ICU care.

"Communicate with patient and/or family (Discuss procedure/ obtain consent)": The time to discuss a patient's procedure with the parent of a child is greater than the typical discussions when an adult patient consents for themselves. This leads to considerably more time for explaining the procedure and consenting the family for the forthcoming procedure.

"Check/ prepare patient readiness (Gown, drape, prep, mark)": Whereas anxiolytic medications are quite often administered to alleviate patient anxiety in a typical pre-operative setting, this is not typical in cardiac patients due to concerns about hemodynamic instability. Therefore, parents are relied upon for significant patient coaching and may even accompany the child to the catheterization lab, where they spend 1-2 minutes comforting the child as the anesthesiologist administers inhalational sedation in a controlled setting.

We recommend 3 additional minutes for positioning, for a total 6 minutes. Survey respondents indicated 15 minutes at the median.

"Perform/ supervise patient positioning": Positioning of these patients is more time consuming. Positioning is complicated by the requirement for bi-plane fluoroscopic equipment. Given the extensive intra-procedure monitoring that is necessary, the myriad of EKG wires (2 sets), IV tubing, pH probe, etc. must be precisely positioned so as not to be in the way of either of the bi-plane imaging views. Patients are then positioned with both arms extended above the head and the legs pigeon toed and secured in this position for femoral access. It is also common to obtain access from both the groin and the neck during the same procedure, which means three points of access (bilateral femoral and right neck) must be prepped and draped in sterile fashion. Additional positioning occurs to move the arm(s) up when operators prefer arms down to obtain neck access. Arm positioning is particularly important for anticipated long procedures to avoid brachial plexus injury. All of this must be done while maintaining a sterile environment.

For postservice time, we recommend 15 additional minutes, consistent with the survey median time of 48 minutes. This would be comprised of 3 additional minutes for application of dressing, 4 additional minutes for monitoring/stabilization, 3 additional minutes communication with patient/family, and 5 additional minutes for the written post-op note.

"Application of dressing": As noted in the description of the post-service package breakdown, the existing times allow for a "simple dressing". Unlike adult catheterization patients, who typically have closure devices placed as part of the intra-procedure time, these devices are not typically used in children, and various dressings are applied instead. Pressure dressings are the most common, but other sites may require additional occlusive dressings (eg. Opsite, Tegaderm) prior to pressure dressing application or by themselves. Patients in the congenital cardiac surgical suite will have dressings applied to multiple sites, including mediastinal and pleural drains, as well as a sternal dressing, which often involves an open sternum.

"Monitor patient recovery/stabilization": Due to the labile hemodynamics most of these patients demonstrate, a prolonged period for monitoring is needed immediately upon completion of the case. This provides additional time for emerging from sedation/anesthesia to prevent dramatic swings in systemic and/or pulmonary vascular resistance.

"Communication with patient and/or family": As explained in the pre-service package for the same issue, communication of complex cardiac findings and interventions is more time consuming for the family of a child as compared to an adult patient with other pathologies. Additionally, the discussion typically extends into explanation of next steps, namely whether or not there is need for complex surgery or medical management.

"Written Post-operative Note": In addition to the traditional immediate post-operative note (a separate line item) a comprehensive post-operative report is documented for these patients. Unlike the typical post procedure report of other specialties for which the existing post procedure package includes 5 minutes, these reports incorporate multiple additional elements including:

a. A list of prior relevant cardiac surgical procedures and the indications for the current procedure;

b. A detailed operative procedure report including all catheter and wire manipulations necessary to catheterize particularly difficult vessels and/or chambers;
c. Summary discussion of the hemodynamic findings including calculations of cardiac index, systemic and pulmonary vascular resistance, and any intra-cardiac shunt fractions;
d. Safe hand-off/communication is made with the hospital rounding team for inpatients returning to their respective units;
e. A complete radiologic report describing all of the findings from the angiograms performed;
f. An anatomically accurate drawing of the cardiac defect(s) is performed, usually using existing software programs (a time-consuming effort that facilitates understanding for all providers); and
g. All data obtained must be duplicated and entered into a national registry, such as IMPACT

33902

Code 33902 is the third code in the family and describes the work of unilateral pulmonary artery stent placement in a heart with abnormal connections. The key reference code is 93590 for percutaneous transcatheter closure of paravalvular leak in the mitral valve. It was selected by 24% of respondents. 62% of the respondents indicated that 33902 is more intense/complex overall, with the remainder responding it is identical. The second reference code is 37231 for endovascular tibial/peroneal atherectomy. It was selected by 18% of respondents. 66% of these respondents felt 33902 to be more intense/complex.

Recommendation

Therefore, for code 33902 the **societies recommend the survey median RVW of 17.33 with 71 minutes preservice time, 90 minutes intraservice time from the survey median, and 48 minutes postservice time**. This aligns reasonably well with the intensity of the KRS, which survey respondents felt was less intense than 33902 but takes longer to perform. It also compares well to the intensity of MPC code 37244 for vascular embolization of a hemorrhage, with work in the congenital cardiac space being more intense for an identical 90-minutes of intraservice time. Additional 000 comparator 93580 is another code common in the congenital cardiac space that could be useful in valuing 33902. It has a longer intraservice time but similar total time, and was identified by respondents elsewhere in this survey to be less intense/complex than pulmonary artery stenting in normal native connections, suggesting it could also be useful here.

As we noted above and discussed with the prefacilitation committee, this recommendation reflects and increased intensity for a service provided in the same amount of time as 33900, the normal connections version of this service. The increased work can be attributed to increased intensity of these services in patients with abnormal connections: interpretations of any other angiographic studies are more difficult; operators are looking for additional lesions throughout the procedure, where in a healthy child with normal connections that complexity doesn't exist; this essentially creates more complex MDM throughout procedure, as the operator is constantly thinking about what else could be wrong. This difference is demonstrated in the increased in IWPUT from 0.129 to 0.165 and the increase in WPUT from 0.068 to 0.083.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. NA

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Interventional Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatric Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. CCA estimate

Specialty Pediatric/Interventional Cardiology Frequency 600 Percentage 60.00 %

Specialty Cardiology Frequency 400 Percentage 40.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is possible that a very small percentage of patients may be beneficiaries

Specialty Pediatric/Interventional Cardiology Frequency 20 Percentage 50.00 %

Specialty Cardiology Frequency 20 Percentage 50.00 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93530

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33903 Tracking Number A4 Original Specialty Recommended RVU: **20.00**
Presented Recommended RVU: **20.00**
Global Period: 000 Current Work RVU: **NA** RUC Recommended RVU: **20.00**

CPT Descriptor: Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, bilateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 5-year-old male with hypoplastic left heart syndrome status post fontan operation is identified by physical exam and subsequent mri to have possible bilateral pulmonary artery stenoses. he is brought to the cardiac catheterization laboratory for further evaluation and possible bilateral stent implantation of the right and left main pulmonary arteries.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review of noninvasive work-up including echocardiogram, CXR, EKG, cardiac CT or MRI, or any other pertinent studies. Based on available information, determine all potential components required for the procedure plus contingencies and backups. Perform and document a complete and/or interval history and physical exam. Provide a description of the procedure and expected results to the parents of the patient, a description of potential risks, and obtain signature of informed consent for the procedure. Supervise the administration of anxiolysis, when necessary. Conduct final procedural coordination with technicians, nurses, and the anesthesiology team. Don surgical scrubs & lead. Position patient. Prep, scrub, drape and wait. Perform a “time-out.”

Description of Intra-Service Work: The procedure is conducted under general anesthesia using fluoroscopic guidance throughout. Lidocaine is injected to the access sites to help minimize hypotension caused by excessive general anesthetic. Vascular access is obtained percutaneously, typically in a large vein and an artery. The site of venous access is variable and depends on patient anatomy and any vascular access limitations. Arterial access is typically obtained in a femoral artery but may require carotid artery access. Introducer sheaths are initially placed over a wire in the vein and artery to establish secure access. The wires and dilators are removed, and the sheaths flushed with heparinized saline. Intravenous heparin is administered to achieve therapeutic anticoagulation. The activated clotting time is monitored throughout the case, and additional heparin is administered, as needed.

Diagnostic catheterization varies due to inconsistent venous or arterial access to the pulmonary arteries. Diagnostic cardiac catheterization (separately reportable, 93593-97) including hemodynamic and angiographic evaluation is initially performed and demonstrates an indication for further intervention. Measurements of the lesion as well as neighboring healthy vessels are made from the angiogram, which is used for selection of the appropriate balloon and stent sizes. The angiographic catheter is removed and an end-hole catheter with soft guidewire advanced into and beyond the stenotic left pulmonary artery lesion. The soft guidewire is replaced with a stiff interventional guidewire to secure a stable position in the distal branch to support the remainder of the intervention. The chosen stent is prepared, mounted and hand-crimped on the appropriate delivery balloon, which has been de-aired to ensure the lowest possible profile. The diagnostic introducer sheath is removed and exchanged for a larger and longer sheath to accommodate delivery of the balloon-mounted stent. The delivery sheath is advanced over the wire to the target location, just distal to the lesion. The dilator is removed, and the

sheath allowed to bleed back to ensure evacuation of any air, then flushed with heparinized saline. The balloon with mounted stent is loaded onto the wire and advanced through the long sheath to the tip of the sheath. The entire system is adjusted to position the stent, still within the sheath, across the lesion. Once in the appropriate location, the sheath is carefully withdrawn partially. An angiogram is performed through the side port of the sheath to evaluate the position. Adjustments are made as needed and angiography repeated until the position is appropriate. The sheath is then withdrawn further, fully exposing the delivery balloon. The balloon is inflated to deliver the stent within the target lesion. The balloon is deflated and removed, maintaining wire position. A larger or higher-pressure balloon catheter may be used to post-dilate the stent to the desired diameter and is not additionally reportable. The balloon is exchanged for a diagnostic catheter to perform hemodynamic assessment of the result. Angiography is also performed to assess the positioning of the delivered stent and potential need for additional intervention. The soft tipped guidewire is then re-inserted through the catheter and advanced into and beyond the stenotic right pulmonary artery and extended into the distal right lower lobe branch. Once again, the guidewire is removed and the stiff interventional wire re-inserted to secure right sided wire position for the subsequent intervention. The entire process described above for the left sided stent is now repeated to address the right pulmonary artery stenosis. Once the right sided lesion is successfully stented, a final main pulmonary artery angiogram is repeated to assess the final result of the bilateral stent implants.
All catheters and sheaths are removed and manual compression or a vascular closure device is used to achieve hemostasis prior to transfer to the recovery area.

Description of Post-Service Work: Following catheterization, an immediate post-procedure note is documented in the medical record. Once hemostasis of the catheterization vascular access sites has been ensured, the patient is transported to the appropriate recovery area and a verbal report given to the accepting team. Medication reconciliation is performed in the EMR and post procedure orders are placed for nursing care. A detailed report is documented which includes an anatomically correct diagram of the congenital heart defects, detailed description of the procedure performed, calculations and interpretation of all the hemodynamic data obtained, review and radiologic interpretation of the angiograms, a complete listing and discussion of the findings, and recommendations based on all of the findings. All necessary data is then also entered into the appropriate national registry, as available/appropriate. There is at least one physician bedside visit to assess the patient, including catheterization sites, discuss the findings with the patient and/or family, and review discharge and follow up instructions prior to discharge. For outpatients, stent implantation will typically require an overnight hospital stay and follow-up testing the next morning, which will be reviewed by the operator. For inpatients, communication/hand-off of the findings is made with the intensive care team, as may be appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Mark Hoyer, Edward Toggart, Afnan Tariq, Richard Wright, Thad Waites, Edward Tuohy					
Specialty Society(ies):	Society for Cardiovascular Angiography and Interventions, American College of Cardiology					
CPT Code:	33903					
Sample Size:	363	**Resp N:**	35			
Description of Sample:	SCAI performed a random survey of 209 Pediatric Interventional Cardiologists and ACC performed a random survey of 163 Pediatric Interventional Cardiologists					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	1.00	**3.00**	5.00	50.00
Survey RVW:	10.00	14.53	**20.00**	24.35	30.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**15.00**		
Pre-Service Scrub, Dress, Wait Time:			**15.00**		
Intra-Service Time:	40.00	90.00	**120.00**	180.00	270.00

Immediate Post Service-Time:	**50.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

4-FAC Difficult Patient/Difficult Procedure

CPT Code:	33903	**Recommended Physician Work RVU: 20.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**50.00**	**40.00**	**10.00**
Pre-Service Positioning Time:		**6.00**	**3.00**	**3.00**
Pre-Service Scrub, Dress, Wait Time:		**15.00**	**20.00**	**-5.00**
Intra-Service Time:		**120.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

9B General Anes or Complex Regional Blk/Cmplx Proc

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**50.00**	**33.00**	**17.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93581	000	24.39	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of a congenital ventricular septal defect with implant

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92928	000	10.96	**RUC Time**

CPT Descriptor Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37244	000	13.75	**RUC Time**	12,731

CPT Descriptor 1 Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for arterial or venous hemorrhage or lymphatic extravasation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
33745	000	20.00	**RUC Time**

CPT Descriptor Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 25.7 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 17.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 33903	Top Key Reference CPT Code: 93581	2nd Key Reference CPT Code: **92928**
Median Pre-Service Time	71.00	30.00	29.00
Median Intra-Service Time	120.00	180.00	76.00
Median Immediate Post-service Time	50.00	60.00	30.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**241.00**	**270.00**	**135.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	56%	0%	33%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	56%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	56%	33%

Physical effort required	38%	25%	37%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	22%	67%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	0%	50%	50%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	17%	83%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	0%	100%
Physical effort required	0%	33%	67%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel approved a new family of five codes at the February Panel meeting describing physician services to describe pulmonary artery stenting after a long shift toward percutaneous endovascular approaches in some patients. While initially balloon angioplasty was the only possible treatment for pulmonary artery stenosis (PAS), particularly for

small children, the use of endovascular stents has developed and improved outcomes versus angioplasty alone. Compared to other peripheral vascular angioplasty and stenting interventions, the work performed in the pulmonary arteries poses greater complexity and risk not captured by other existing peripheral vascular CPT codes. Additionally, there is currently no way in CPT to track patients undergoing endovascular repair of PAS due to the large number of patients treated for other pathologies with any of the existing codes that are used to report this work.

CPT codes 33900-33904 are for endovascular repair of pulmonary artery stenosis by stent placement. Codes 33900 and 33901 are for stent placement within the pulmonary arteries via normal native connections, defined as venous access through normal right heart structures and chambers. Codes 33902 and 33903 are for stent placement within the pulmonary arteries, ductus arteriosus, or within a surgical shunt, via abnormal connections or through post-surgical shunts (eg, Blalock-Taussig shunt, Sano shunt, or post Glenn or Fontan procedures). Code 33904 is for each additional stent placed at any location via normal or abnormal connections. Due to the extreme variability of the underlying diagnosis associated with pulmonary artery stenosis, it is impossible to determine if a right heart only, left heart only, or combined right and left diagnostic study is needed. Therefore, congenital diagnostic cardiac catheterization is separately reportable with CPT codes 93593-93597.

Survey of the codes was deferred one meeting while some introductory coding language was revised by the Panel in consultation with the specialties. Specialty societies randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The 000-global day survey was completed by physicians who have experience with the service.

As we move through this family of codes, there are three relationships in which we anticipate the RUC will be interested. The first is an increase in time and work as the codes move from unilateral to bilateral. That relationship exists and appears appropriate to the expert panel, with increased time and work for bilateral procedures. The second is an increase in work as the codes move from “normal native” connections to “abnormal” connections. That relationship also exists and appears appropriate to the expert panel. The final relationship that one might expect to see but does not exist is an increase in time as the codes move from “normal native” connections to “abnormal” connections. We can speak to this in greater detail during discussion of the abnormal codes at the meeting, but will explain here that while the times may be the same, the increased work can be attributed to increased intensity of these services in patients with abnormal connections: interpretations of any other angiographic studies are more difficult; operators are looking for additional lesions throughout the procedure, where in a healthy child with normal connections that complexity doesn’t exist; this essentially creates more complex MDM throughout procedure, as the operator is constantly thinking about what else could be wrong.

Finally, we note a logical progression in WPUT throughout the family as we progress from unilateral stenting in normal native connections to bilateral stenting in abnormal connections, from 0.068 to 0.076 to 0.083 and 0.083, respectively, that we suggest supports the time and RVU recommendations.

Preservice/Postservice

The societies have sought, and the RUC has approved additional time in similar circumstances at several recent meetings, with additional time most commonly added for review of records/imaging, extended discussions with family/parents, additional positioning, additional wound dressing, prolonged monitoring, and extensive documentation (eg. anatomically correct diagram with hemodynamic data embedded). Those elements apply with this family of codes, and we describe recommendations beyond traditional standards here.

Separately at this meeting, the societies submitted information requesting a degree of standardization for additional time in the preservice and postservice periods to reflect complicating factors physicians face when treating patients in need of complex congenital cardiac procedures. The Research Subcommittee opted not to pursue a standardized addition, but rather to consider requests for additional time for complex congenital cardiac procedures on an ad hoc basis when each code is presented. Insofar as surveys supported times beyond the standards in Preservice Package 4 and Postservice Package 9B, we have made recommendations for additional preservice and postservice time consistent with that submission.

For 33903 that results in a recommendation for 10 additional minutes of evaluation time—with 5 additional minutes for prepare for the procedure, 3 additional minutes for communication/consent with patient/family, and 2 additional minutes to prepare/gown/drape the patient. This produces a recommendation of 50 minutes preservice evaluation time rather than 40. Survey respondents indicated 62 minutes at the median.

"Prepare for Procedure (Check labs, plan, assess risks, review procedure)": Time to prepare for the procedure is considerable. The typical patient has extensive past cardiac history. It is vital to review their past cardiac catheterization reports, angiographic imaging, any existing CT or cardiac MR, and prior surgical history. Previous percutaneous access issues must also be reviewed including from prior cardiac catheterization procedures or long standing CVL placement during ICU care.

"Communicate with patient and/or family (Discuss procedure/ obtain consent)": The time to discuss a patient's procedure with the parent of a child is greater than the typical discussions when an adult patient consents for themselves. This leads to considerably more time for explaining the procedure and consenting the family for the forthcoming procedure.

"Check/ prepare patient readiness (Gown, drape, prep, mark)": Whereas anxiolytic medications are quite often administered to alleviate patient anxiety in a typical pre-operative setting, this is not typical in cardiac patients due to concerns about hemodynamic instability. Therefore, parents are relied upon for significant patient coaching and may even accompany the child to the catheterization lab, where they spend 1-2 minutes comforting the child as the anesthesiologist administers inhalational sedation in a controlled setting.

We recommend 3 additional minutes for positioning, for a total 6 minutes. Survey respondents indicated 15 minutes at the median.

"Perform/ supervise patient positioning": Positioning of these patients is more time consuming. Positioning is complicated by the requirement for bi-plane fluoroscopic equipment. Given the extensive intra-procedure monitoring that is necessary, the myriad of EKG wires (2 sets), IV tubing, pH probe, etc. must be precisely positioned so as not to be in the way of either of the bi-plane imaging views. Patients are then positioned with both arms extended above the head and the legs pigeon toed and secured in this position for femoral access. It is also common to obtain access from both the groin and the neck during the same procedure, which means three points of access (bilateral femoral and right neck) must be prepped and draped in sterile fashion. Additional positioning occurs to move the arm(s) up when operators prefer arms down to obtain neck access. Arm positioning is particularly important for anticipated long procedures to avoid brachial plexus injury. All of this must be done while maintaining a sterile environment.

For postservice time, we recommend 17 additional minutes, consistent with the survey median time of 50 minutes. This would be comprised of 3 additional minutes for application of dressing, 5 additional minutes for monitoring/stabilization, 4 additional minutes communication with patient/family, and 5 additional minutes for the written post-op note.

"Application of dressing": As noted in the description of the post-service package breakdown, the existing times allow for a "simple dressing". Unlike adult catheterization patients, who typically have closure devices placed as part of the intra-procedure time, these devices are not typically used in children, and various dressings are applied instead. Pressure dressings are the most common, but other sites may require additional occlusive dressings (eg. Opsite, Tegaderm) prior to pressure dressing application or by themselves. Patients in the congenital cardiac surgical suite will have dressings applied to multiple sites, including mediastinal and pleural drains, as well as a sternal dressing, which often involves an open sternum.

"Monitor patient recovery/stabilization": Due to the labile hemodynamics most of these patients demonstrate, a prolonged period for monitoring is needed immediately upon completion of the case. This provides additional time for emerging from sedation/anesthesia to prevent dramatic swings in systemic and/or pulmonary vascular resistance.

"Communication with patient and/or family": As explained in the pre-service package for the same issue, communication of complex cardiac findings and interventions is more time consuming for the family of a child as compared to an adult patient with other pathologies. Additionally, the discussion typically extends into explanation of next steps, namely whether or not there is need for complex surgery or medical management.

"Written Post-operative Note": In addition to the traditional immediate post-operative note (a separate line item) a comprehensive post-operative report is documented for these patients. Unlike the typical post procedure report of other specialties for which the existing post procedure package includes 5 minutes, these reports incorporate multiple additional elements including:

a. A list of prior relevant cardiac surgical procedures and the indications for the current procedure;
b. A detailed operative procedure report including all catheter and wire manipulations necessary to catheterize particularly difficult vessels and/or chambers;
c. Summary discussion of the hemodynamic findings including calculations of cardiac index, systemic and pulmonary vascular resistance, and any intra-cardiac shunt fractions;
d. Safe hand-off/communication is made with the hospital rounding team for inpatients returning to their respective units;
e. A complete radiologic report describing all of the findings from the angiograms performed;
f. An anatomically accurate drawing of the cardiac defect(s) is performed, usually using existing software programs (a time-consuming effort that facilitates understanding for all providers); and
g. All data obtained must be duplicated and entered into a national registry, such as IMPACT

33903

Code 33903 is the fourth code in the family and describes the work of bilateral pulmonary artery stent placement in a heart with abnormal connections. The key reference code is 93581 for percutaneous transcatheter closure of a congenital ventricular septal defect. It was selected by 26% of respondents. 56% of the respondents indicated that 33903 is identical in overall intensity/complexity, with 33% indicating it is much more intense complex. The second reference code is 92928 for percutaneous coronary stenting. It was selected by 17% of respondents. 100% of these respondents felt 33903 to be more intense/complex.

Recommendation

Therefore, for code 33903 the **societies recommend the survey median RVW of 20.00 with 71 minutes preservice time, 120 minutes intraservice time from the survey median, and 50 minutes postservice time**. This fits between the times and work RVUs of the two KRSs, with an appropriately higher intensity. Additional comparator 33745 for transcatheter intracardiac shut creation through stent placement may be useful for comparison. This recently valued service is for another congenital/pediatric patient procedure. 33745 has the same work RVU, but a shorter time and appropriately higher intensity, as it is performed on patients with poor hemodynamics and who are poor surgical candidates.

As we noted above and discussed with the prefacilitation committee, this recommendation reflects and increased intensity for a service provided in the same amount of time as 33901, the normal connections version of this service. The increased work can be attributed to increased intensity of these services in patients with abnormal connections: interpretations of any other angiographic studies are more difficult; operators are looking for additional lesions throughout the procedure, where in a healthy child with normal connections that complexity doesn't exist; this essentially creates more complex MDM throughout procedure, as the operator is constantly thinking about what else could be wrong. This difference is demonstrated in the increased in IWPUT from 0.130 to 0.146 and the increase in WPUT from 0.076 to 0.083. It is also notable that the WPUT for this code is identical to the prior, which makes sense to the expert panel, and supports the recommendations.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. NA

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93799

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Interventional Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatric Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate from CPT CCA.

Specialty Pediatric/Interventional Cardiology Frequency 300 Percentage 60.00 %

Specialty Cardiology Frequency 200 Percentage 40.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is possible that a very small percentage of patients may be beneficiaries

Specialty Pediatric/Interventional Cardiology Frequency 20 Percentage 50.00 %

Specialty Cardiology Frequency 20 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93530

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:33904 Tracking Number A5 Original Specialty Recommended RVU: **7.27**
Presented Recommended RVU: **7.27**
Global Period: ZZZ Current Work RVU: **NA** RUC Recommended RVU: **7.27**

CPT Descriptor: Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections (list separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During congenital cardiac catheterization for suspected pulmonary artery stenosis, a 4-year-old female who has just undergone bilateral stent implant via abnormal connections, requires additional stent implants for additional lesions not previously identified. she undergoes additional segmental pulmonary arterial stent implant in the right and left upper branches (note: this is an add-on code for the additional work related to stent placement of each additional vessel or separate lesion [normal or abnormal] of percutaneous pulmonary artery revascularization. the work related to the first percutaneous pulmonary artery revascularization by stent placement is reported separately as the primary procedure and not included in the work of this add-on code).

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: The work for 33904 begins following completion of primary stent implantation in the left and/or right main pulmonary arteries. Hemodynamic and angiographic evaluation identifies multiple segmental branch pulmonary artery stenoses. After selective angiography (separately reported) is performed in the right lower lobe segmental branch, an end-hole catheter with soft guidewire is advanced into and beyond the stenotic right lower lobe lesion. The soft guidewire is replaced with a stiff interventional guidewire to secure a stable position in the distal branch to support the remainder of the intervention. The chosen stent is prepared, mounted and hand-crimped on the appropriate delivery balloon, which has been de-aired to ensure the lowest possible profile. The delivery sheath is advanced over the wire to the target location, just distal to the lesion. The dilator is removed, and the sheath allowed to bleed back to ensure evacuation of any air, then flushed with heparinized saline. The balloon with mounted stent is loaded onto the wire and advanced through the long sheath to the tip of the sheath. The entire system is adjusted to position the stent, still within the sheath, across the lesion. Once in the appropriate location, the sheath is carefully withdrawn partially. An angiogram is performed through the side port of the sheath to evaluate the position. Adjustments are made as needed and angiography repeated until the position is appropriate. The sheath is then withdrawn further, fully exposing the delivery balloon. The balloon is inflated to deliver the stent within the target lesion. The balloon is deflated and removed, maintaining wire position. A larger or higher-pressure balloon catheter may be used to post-dilate the stent to the desired diameter and is not additionally reportable. Hemodynamic and angiographic evaluation is repeated to assess the result. The entire process described above for the right lower lobe stent is now repeated in the right upper lobe, left lower lobe, and left upper lobe to address these additional bilateral segmental stenoses. All catheters and sheaths are removed and manual compression or a vascular closure device is used to achieve hemostasis prior to transfer to the recovery area.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Mark Hoyer, Edward Toggart, Afnan Tariq, Richard Wright, Thad Waites, Edward Tuohy					
Specialty Society(ies):	Society for Cardiovascular Angiography and Interventions, American College of Cardiology					
CPT Code:	33904					
Sample Size:	363	**Resp N:**	35			
Description of Sample:	SCAI performed a random survey of 209 Pediatric Interventional Cardiologists and ACC performed a random survey of 163 Pediatric Interventional Cardiologists					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**4.00**	10.00	50.00
Survey RVW:	4.25	5.53	**7.27**	9.25	30.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	20.00	30.00	**45.00**	65.00	180.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	33904	**Recommended Physician Work RVU: 7.27**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
37237	ZZZ	4.25	**RUC Time**

CPT Descriptor Transcatheter placement of an intravascular stent(s) (except lower extremity artery(s) for occlusive disease, cervical carotid, extracranial vertebral or intrathoracic carotid, intracranial, or coronary), open or percutaneous, including radiological supervision and interpretation and including all angioplasty within the same vessel, when performed; each additional artery (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
33746	ZZZ	8.00	**RUC Time**

CPT Descriptor Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catherization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
34812	ZZZ	4.13	**RUC Time**	9,013

CPT Descriptor 1 Open femoral artery exposure for delivery of endovascular prosthesis, by groin incision, unilateral (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
		0.00		

CPT Descriptor 2

Other Reference CPT Code	Global	Work RVU	Time Source
93592	000	8.00	**RUC Time**

CPT Descriptor Percutaneous transcatheter closure of paravalvular leak; each additional occlusion device (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 25.7 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 22.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 33904	Top Key Reference CPT Code: 37237	2nd Key Reference CPT Code: **33746**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	45.00	45.00	60.00
Median Immediate Post-service Time	0.00	1.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**45.00**	**46.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	44%	34%	22%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	33%	67%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	22%	78%
Physical effort required	0%	33%	67%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	56%	44%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	25%	38%	37%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	63%	12%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	25%	38%	37%
Physical effort required	29%	43%	28%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	50%	25%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

33904

Code 33904 is the final code in the family and describes the work of placement of an additional stent in any of the previous four services. The key reference code is 37237 for transcatheter placement of each additional intravascular stent. It was selected by 26% of respondents. 56% of the respondents indicated that 33904 is more overall intensity/complexity, with the remaining 44% indicating it is identical intensity/complexity. The second reference code is 33746 for transcatheter intracardiac shunt creation through stent placement. It was selected by 23% of respondents. 38% of these respondents felt 33904 to be of identical intensity/complexity, with the balance roughly split on it being more or less intense/complex.

Recommendation

Therefore, for code 33904 the **societies recommend the survey median RVW of 7.27 with 45 minutes intraservice time from the survey median and 45 minutes total time**. This fits between the work RVUs of the two KRSs. Additional comparator 93592 for percutaneous transcatheter closure of an additional paravavular leak may be useful for comparison. This recently valued service is for another percutaneous cardiac procedure. Because both the MPC comparator 93592 and the second KRS 33746 have longer time and higher RVU, they support our recommended value as not being too high. Additionally, though the time for this service is the same as the first KRS (45 minutes), its higher intensity justifies our recommendation for a value higher than for 37237.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93799

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatric Interventional Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatric Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1000

If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate from CPT CCA.

Specialty Pediatric/Interventional Cardiology Frequency 600 Percentage 60.00 %

Specialty Cardiology Frequency 400 Percentage 40.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. It is possible that a very small percentage of patients may be beneficiaries

Specialty Pediatric/Interventional Cardiology Frequency 20 Percentage 50.00 %

Specialty Cardiology Frequency 20 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93530

SS Rec Summary

ISSUE: Endovascular Pulmonary Arterial Revascularization

TAB: 4

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	pt/sa 91	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	92928	0	Percutaneous transcatheter placement of intracoronary	2012	12	0.128	0.081			10.96			135	23	1	5			76			30						
2nd REF	93580	0	Percutaneous transcatheter closure of congenital interatrial	2002	9	0.133	0.086			17.97			210	30	0	0			120			60						
CURRENT	93799		Unlisted cardiovascular procedure																									
SVY	33900	0	Percutaneous pulmonary artery revascularization by stent		35	0.124	0.062	8.00	11.03	14.00	18.00	23.57	227	62	15	15	20	60	90	118	200	45		2	8	12	20	75
REC	33900	0	Percutaneous pulmonary artery revascularization by stent			0.129	0.068			14.00			206	50	6	15			90			45						
MPC	37244	0	Vascular embolization or occlusion, inclusive of all	2013		0.135	0.083			13.75			166	23	3	5			90			45						
COMP	33340	0	Percutaneous transcatheter closure of the left atrial	2016		0.136	0.077			14.00			183	40	3	20			90			30						

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	pt/sa 91	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93580	0	Percutaneous transcatheter closure of congenital interatrial	2002	9	0.133	0.086			17.97			210	30	0	0			120			60						
2nd REF	92928	0	Percutaneous transcatheter placement of intracoronary	2012	8	0.128	0.081			10.96			135	23	1	5			76			30						
CURRENT	93799		Unlisted cardiovascular procedure																									
SVY	33901	0	Percutaneous pulmonary artery revascularization by stent		35	0.125	0.069	10.00	14.50	18.00	22.05	26.70	262	67	15	15	35	90	120	160	250	45		0	2	5	8	50
REC	33901	0	Percutaneous pulmonary artery revascularization by stent			0.130	0.076			18.00			236	50	6	15			120			45						
COMP	93591	0	Percutaneous transcatheter closure of paravalvular leak; initial	2016		0.135	0.086			17.97			208	40	3	15			120			30						

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	pt/sa 91	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93590	0	Percutaneous transcatheter closure of paravalvular leak; initial	2016	8	0.148	0.097			21.70			223	40	3	15			135			30						
2nd REF	37231	0	Revascularization, endovascular, open or percutaneous, tibial,	2010	6	0.099	0.073			14.75			203	30	3	5			135			30						
CURRENT	93799		Unlisted cardiovascular procedure																									
SVY	33902	0	Percutaneous pulmonary artery revascularization by stent		34	0.158	0.073	8.00	14.00	17.33	21.51	26.00	238	70	15	15	30	62	90	129	220	48		0	4	7	15	75
REC	33902	0	Percutaneous pulmonary artery revascularization by stent			0.165	0.083			17.33			209	50	6	15			90			48						
COMP	93580	0	Percutaneous transcatheter closure of congenital interatrial	2002		0.133	0.086			17.97			210	30	0	0			120			60						

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	pt/sa 91	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93581	0	Percutaneous transcatheter closure of a congenital ventricular	2002	9	0.124	0.090			24.39			270	30	0	0			180			60						
2nd REF	92928	0	Percutaneous transcatheter placement of intracoronary	2012	6	0.128	0.081			10.96			135	23	1	5			76			30						
CURRENT	93799		Unlisted cardiovascular procedure																									
SVY	33903	0	Percutaneous pulmonary artery revascularization by stent		35	0.140	0.074	10.00	14.53	20.00	24.35	30.00	270	70	15	15	40	90	120	180	270	50		0	1	3	5	50
REC	33903	0	Percutaneous pulmonary artery revascularization by stent			0.146	0.083			20.00			241	50	6	15			120			50						
COMP	33745	0	Transcatheter intracardiac shunt (TIS) creation by stent placement	2020		0.192	0.097			20.00			207	25	15	15			92			60						

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	pt/sa 91	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	37237	ZZZ	Transcatheter placement of an intravascular stent(s) (except	2013	9	0.093	0.090			4.25			47	1					45			1						
2nd REF	33746	ZZZ	Transcatheter intracardiac shunt (TIS) creation by stent placement	2020	8	0.133	0.133			8.00			60						60									
CURRENT	93799		Unlisted cardiovascular procedure																									
SVY	33904	ZZZZ	Percutaneous pulmonary artery revascularization by stent		35	0.162	0.162	4.25	5.53	7.27	9.25	30.00	45	0	0	0	20	30	45	65	180	0		0	2	4	10	50
REC	33904	ZZZ	Percutaneous pulmonary artery revascularization by stent			0.162	0.162			7.27			45						45									
COMP	93592	ZZZ	Percutaneous transcatheter closure of paravalvular leak; each	2016		0.133	0.133			8.00			60						60									

September 8, 2021

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Avenue
Chicago, IL 60611

Re: Tab 4 Endovascular Pulmonary Arterial Revascularization

Dear Dr. Manaker:

Tab 4 on the October 2021 RUC agenda addresses five new codes, which describe endovascular repair of pulmonary artery stenosis by stent placement. All five of these services will be provided exclusively in the facility setting with 000 or ZZZ global periods. As such, the Society for Cardiovascular Angiography and Interventions and the American College of Cardiology recommend no direct practice expense inputs for Tab 4.

Thank you for your consideration of this information as you prepare for the upcoming meeting. Please contact Debra Mariani at jvavricek@acc.org if you have any questions.

Sincerely,

Edward Toggart, MD
SCAI RUC Advisor

Richard Wright, MD
ACC RUC Advisor

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

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September 15, 2021

Ezequiel Silva III, MD
Chairperson, AMA/Specialty Society RVS Update Committee
Relative Value Systems, American Medical Association
330 N Wabash Ave, Suite 39300
Chicago, IL 60611

Re: Tab 4 Endovascular Pulmonary Arterial Revascularization (Codes 33900-33904)

Dear Doctor Silva:

The American Academy of Pediatrics (AAP) would like to offer comments on codes 33900-33903 (*Percutaneous pulmonary artery revascularization by stent placement, initial*) and 33904 (*Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion*).

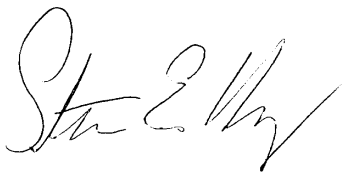
These procedures follow the model established by the new congenital cardiac catheterization codes, reflecting increased complexity as one moves from normal to abnormal native connections. These procedures represent advances in technology of stenting for pulmonary revascularization as opposed to balloon angioplasty.

Of the 363 who were surveyed, 45% were pediatric interventional cardiologists represented by the ACC, and we appreciate the ACC's inclusion of such a large number of pediatric cardiologists in its sample. Therefore, we believe that the survey results are representative from a pediatric perspective, especially with regard to the median values, which acknowledge pediatric cardiology complexity. Despite the fact that the sequence of procedures (33900 through 33904) address normal versus abnormal native connections as well as unilateral versus bilateral work, rank order median values were maintained as complexity increased.

The AAP is fully supportive of these recommendations.

Thank you for the opportunity to comment.

Sincerely,



Steven E. Krug, MD, FAAP
AAP RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth (76942)

October 2021

Somatic Nerve Injections – Tab 5

In October 2015, CPT code 76942 was identified under the high volume growth screen and the RUC noted to review the utilization in October 2017. In October 2017, this code appeared on an agenda tab, but it was not surveyed. Therefore, the RUC indicated that this service was not addressed via this flag because the Relativity Assessment Workgroup (RAW) thought it was going to be addressed from the RUC survey process. In January 2018, the RAW reviewed this issue and noted that this service was recently bundled in 2015 and the clinical staff time is not duplicative.

In May 2018, the CPT Editorial Panel approved the revision of descriptors and guidelines for codes 64400-64450 and deletion of three codes to clarify reporting (i.e., separate reporting of imaging guidance, number of units, change of CPT codes 64421 from a 000-day global to ZZZ). Codes 64400-64450 describe the injection of an anesthetic agent(s) and/or steroid into a nerve plexus, nerve, or branch. These codes are reported once per nerve plexus, nerve, or branch as described in the descriptor regardless of the number of injections performed along the nerve plexus, nerve, or branch described by the code. Image guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately. The physician work for this family of services varies based on the anatomic location of each nerve, whether the service is typically performed in the facility setting, the typical approach used by the dominant specialty to access the nerve that performs each service and whether the service involves continuous infusion by catheter.

During the October 2018 RUC presentation of the Somatic Nerve Injection family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 64447, and 64448 were reported with code 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* more than 50 percent of the time. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the CPT 2021 cycle. This overlap was accounted for in the RUC recommendations for these services. The RUC referred CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942, to the CPT Editorial Panel for CPT 2021. In September 2019, this issue was postponed until after the CPT Imaging Guidance Workgroup completed its work.

In May 2021, the CPT Editorial Panel approved the revision of ten codes to add "including imaging guidance, when performed" to the descriptors and to revise the introductory guidelines to report these services. CPT codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 are now bundled and the parenthetical appropriately notes "Do not report in conjunction with 76942, 77002, 77003."

Bundled Injection Codes
The RUC discussed the time and intensity for CPT codes 64415-64417 and 64445-64448 for the survey 25th percentile work RVU recommendations. The RUC noted decreases in the intra-service time for some of the codes and discussed that in general when surveying these codes with imaging now bundled, they would not expect the intra-service time to significantly increase because the imaging and injection

physician work are occurring simultaneously. Similarly, the RUC considered the increased intensity of the surveyed codes and noted it is appropriate because the surveyed codes describe the physician work of doing both the injection and imaging simultaneously, wherein the previous codes only described the physician work of doing the injection alone. In reviewing the intensity, the RUC concluded that it provided further support for the appropriateness of the recommendations at the 25th percentile.

During the discussion of the bundled injection codes, the RUC questioned if it would be typical that an anesthesia code would be reported on the same date by the same physician and the specialty clarified that it should not be typical.

64415 ***Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed***
The RUC reviewed the survey results from 86 anesthesiologists and interventional pain physicians and recommends the survey 25th percentile work RVU of 1.50 for CPT code 64415, noting that the brachial plexus injection requires more work than axillary, sciatic and femoral nerve injection without continuous infusion by catheter codes. The RUC recommends the following physician time components: 13 minutes pre-service evaluation, 1 minute pre-service positioning, 4 minutes pre-service scrub/dress/wait time, 10 minutes intra-service time, and 7 minutes immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.50, the RUC compared the surveyed code to the top key reference code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU= 1.27, 15 minutes pre-service time, 10 minutes intra-service time and 10 minutes immediate post-service time) and noted that the codes have identical intra-service and total times, yet the reference code involves less intense physician work. Similarly, of the survey respondents that selected this key reference service, 65% indicated that the surveyed code was more intense and complex. Therefore, 64415 is appropriately valued higher than the top key reference code.

The RUC also compared 64415 to the second highest key reference code 62323 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.80, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that the surveyed code has less intra-service time and less total time than the reference code and therefore is appropriately valued lower. The RUC further noted that the key reference services appropriately bracket the surveyed code. The RUC concluded that CPT code 64415 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.50 for CPT code 64415.**

64416 ***Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed***
The RUC reviewed the survey results from 79 anesthesiologists and interventional pain physicians and recommends the survey 25th percentile work RVU of 1.80 for CPT code 64416, noting that the brachial plexus injection requires more work than the axillary, sciatic and femoral nerve injection without continuous infusion by catheter codes and that the additional 5 minutes of intra-service time for the catheter placement is appropriate. The RUC recommends the following physician time components: 13 minutes pre-service evaluation, 1 minute pre-service positioning, 5 minutes pre-service scrub/dress/wait time, 15 minutes intra-service time, and 10 minutes immediate post-service time. This service is typically

performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.80, the RUC compared the surveyed code to the top key reference code 62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU= 2.20, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that the codes have identical intra-service times and similar total times, yet the surveyed code involves less intense physician work and is therefore appropriately valued lower than the top key reference code.

The RUC also noted the close comparison of 64416 to the second highest key reference code 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.90, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time). The codes have identical intra-service times and similar total times, yet the surveyed code involves slightly less intense physician work and therefore is appropriately valued slightly lower than the reference code.

For additional support, the RUC noted that the multi-specialty points of comparison codes, MPC code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10, 12 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time) and MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 24 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time), appropriately bracket the surveyed code. The RUC concluded that CPT code 64416 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.80 for CPT code 64416.**

64417 ***Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed***
The RUC reviewed the survey results from 79 anesthesiologists and interventional pain physicians and determined that the survey 25th percentile work RVU of 1.31 for CPT code 64417 appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components: 13 minutes pre-service evaluation, 1 minute pre-service positioning, 4 minutes pre-service scrub/dress/wait time, 10 minutes intra-service time, and 10 minutes immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.31, the RUC compared the surveyed code to the top key reference code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU= 1.27, 15 minutes pre-service time, 10 minutes intra-service time and 10 minutes immediate post-service time) and noted the close comparison with identical intra-service times, similar total times and intensity, and comparable amount of physician work. The RUC also compared 64417 to the second highest key reference code 62323 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid,*

other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT) (work RVU = 1.80, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that the surveyed code has less intra-service time and involves less intense physician work than the reference code and therefore is appropriately valued lower.

For additional support, the RUC noted that the multi-specialty points of comparison codes, MPC code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10, 12 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time) and MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 24 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time), appropriately bracket the surveyed code. The RUC concluded that CPT code 64417 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.31 for CPT code 64417.**

64445 *Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed*
The RUC reviewed the survey results from 76 anesthesiologists and interventional pain physicians and determined that the survey 25th percentile work RVU of 1.39 for CPT code 64445 appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components: 7 minutes pre-service evaluation, 1 minute pre-service positioning, 1 minute pre-service scrub/dress/wait time, 10 minutes intra-service time, and 5 minutes immediate post-service time.

To support a work value of 1.39, the RUC compared the surveyed code to the top key reference code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU= 1.27, 15 minutes pre-service time, 10 minutes intra-service time and 10 minutes immediate post-service time) and noted that the codes have identical intra-service times, yet the surveyed code involves more intense physician work focused on the sciatic nerve. Similarly, of the survey respondents that selected this key reference service, 96% indicated that the surveyed code was identical or more intense and complex relative to the key reference service. Therefore, 64445 is appropriately valued higher than the top key reference code.

The RUC also compared 64445 to the second highest key reference code 62323 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.80, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that the surveyed code has less intra-service time and less total time than the reference code and therefore is appropriately valued lower. The RUC further noted that the key reference services appropriately bracket the surveyed code. The RUC concluded that CPT code 64445 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.39 for CPT code 64445.**

64446 ***Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed***
The RUC reviewed the survey results from 60 anesthesiologists and interventional pain physicians and recommends the survey 25th percentile work RVU of 1.75 for CPT code 64446, noting that the additional 5 minutes of intra-service time for the catheter placement is appropriate. The RUC recommends the following physician time components: 13 minutes pre-service evaluation, 1 minute pre-service positioning, 5 minutes pre-service scrub/dress/wait time, 15 minutes intra-service time, and 10 minutes immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.75, the RUC compared the surveyed code to both the top key reference code 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.90, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and the second highest key reference code 62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU= 2.20, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that, in both cases, the codes have identical intra-service times, yet the surveyed code involves less intense physician work and therefore is appropriately valued lower than the reference codes.

For additional support, the RUC noted that the multi-specialty points of comparison codes, MPC code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10, 12 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time) and MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 24 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time), appropriately bracket the surveyed code. The RUC concluded that CPT code 64446 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.75 for CPT code 64446.**

64447 ***Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed***
The RUC reviewed the survey results from 76 anesthesiologists and interventional pain physicians and determined that the survey 25th percentile work RVU of 1.34 for CPT code 64447 appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components: 12 minutes pre-service evaluation, 1 minute pre-service positioning, 3 minutes pre-service scrub/dress/wait time, 8 minutes intra-service time, and 5 minutes immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.34, the RUC compared the surveyed code to the top key reference code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU= 1.27, 15

minutes pre-service time, 10 minutes intra-service time and 10 minutes immediate post-service time) and noted that the surveyed code has less intra-service time than the reference code and involves more intense physician work next to a major vessel and nerve as opposed to the abdominis plane. Therefore, 64447 is appropriately valued higher than the top reference code. Similarly, of the survey respondents that selected this top key reference service, 97% indicated that the surveyed code was identical or more intense and complex relative to the reference service.
The RUC also compared 64447 to the second highest key reference code 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (work RVU = 1.52, 17 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that the surveyed code has less intra-service time and less total time than the reference code and therefore is appropriately valued lower. The RUC further noted that the key reference services appropriately bracket the surveyed code. The RUC concluded that CPT code 64447 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.34 for CPT code 64447.**

64448 ***Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed***
The RUC reviewed the survey results from 62 anesthesiologists and interventional pain physicians and recommends the survey 25th percentile work RVU of 1.68 for CPT code 64448, noting that the additional 7 minutes of intra-service time for the catheter placement is appropriate. The RUC recommends the following physician time components: 13 minutes pre-service evaluation, 1 minute pre-service positioning, 5 minutes pre-service scrub/dress/wait time, 15 minutes intra-service time, and 9 minutes immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than somatic nerve injection services that are typically performed in the non-facility setting.

To support a work value of 1.68, the RUC compared the surveyed code to both the top key reference code 62327 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)* (work RVU = 1.90, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and the second highest key reference code 62325 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)* (work RVU= 2.20, 20 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time) and noted that, in both cases, the codes have identical intra-service times and similar total times, yet the surveyed code involves less intense physician work and therefore is appropriately valued lower than the reference codes.

For additional support, the RUC noted that the multi-specialty points of comparison codes, MPC code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10, 12 minutes pre-service time, 10 minutes intra-service time and 5 minutes immediate post-service time) and MPC code 64483 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level* (work RVU = 1.90, 24 minutes pre-service time, 15 minutes intra-service time and 10 minutes immediate post-service time), appropriately bracket the surveyed code. The RUC concluded that CPT code 64448 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.68 for CPT code 64448.**

Imaging Codes
There are three codes which capture the imaging guidance component of the somatic nerve injection procedures that will no longer be reported separately with codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448, as their work is now bundled into each revised CPT code.

76942 ***Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation***
The RUC reviewed the survey results from 98 physicians and determined that maintaining the current work RVU of 0.67, which falls below the survey 25th percentile, appropriately accounts for the physician work involved in this service. The RUC recommends the following physician time components: 7 minutes pre-service evaluation time, 15 minutes intra-service time, and 5 minutes immediate post-service time as supported by the survey.

The RUC compared CPT code 76942 to the top key reference code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU = 0.56, 10 minutes intra-service time and 18 minutes total time) and noted that the surveyed code has 5 minutes more intra-service time and more total time than the top key reference code and therefore is appropriately valued higher. The reference service is a comparable ultrasound procedure based on the type of imaging performed and the interpretation of the images obtained. Comparatively, the surveyed code typically requires more pre-service time to review the pre-existing images for the needle target and more real-time imaging to guide the needle during the procedure. This contributes to the 5 additional intra-service minutes and overall greater total time for 76942, along with higher value relative to the top key reference service.

The RUC also compared 76942 to the second highest key reference code 38221 *Diagnostic bone marrow; biopsy(ies)* (work RVU = 1.28-, and 20-minutes intra-service time and 50 minutes total time) which is a biopsy procedure performed without imaging guidance and noted that the surveyed code is appropriately valued lower given it has less intra-service time, less total time and involves less intense physician work than the reference service.

For additional support, the RUC compared CPT code 76942 to MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70, 2 minutes pre-service evaluation time, 15 minutes intra-service time and 3 minutes immediate post-service time) and noted that the codes have identical intra-service times yet the multi-specialty points of comparison code involves slightly more intense physician work than the surveyed code, justifying the recommendation. The RUC concluded that the value of CPT code 76942 should be maintained at 0.67 work RVUs, below the 25th percentile of the survey. **The RUC recommends a work RVU of 0.67 for CPT code 76942.**

77002 ***Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 91 physicians and determined that maintaining the current work RVU of 0.54 appropriately accounts for the physician work involved in this add-on service, which is supported by the survey 25th percentile work RVU. The RUC recommends the following physician time components: 2 minutes pre-service positioning time, 15 minutes intra-service time, and 0 minutes post-service time.

CPT codes 77002 and 77003 were once XXX global period codes, but CMS determined that the vignettes and parentheticals for these codes were consistent with that of add-on codes and requested that the societies survey them as ZZZ codes in October 2015. At that time, the existing times

for both 77002 and 77003 were 7 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service. At the October 2015 meeting, the RUC recommended reducing the pre-service time to 2 minutes instead of 7 minutes. The 2 minutes of pre-service time is based on the difference in pre-service positioning time between the epidural injection without imaging guidance (CPT code 62320) and with imaging guidance (CPT code 62321) codes. This is the reason why these add-on services include pre-service time.

The RUC compared CPT code 77002 to the top key reference code 77001 *Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)* (work RVU = 0.38, 2 minutes pre-service positioning time, 15 minutes intra-service time and 0 minutes immediate post-service time) and noted that the add-on codes have the exact same times, including 2 minutes for pre-service positioning, yet the surveyed code involves more intense physician work and therefore is appropriately valued higher than the reference code. CPT code 77002 pertains to fluoroscopic guidance for needle placement during a percutaneous procedure and typically may involve contrast injection or tissue sampling to aid in confirming the position. Comparatively, the reference service involves fluoroscopic guidance through an existing venous access.

The RUC also compared 77002 to the second highest key reference code 10008 *Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)* (work RVU = 1.18, 20 minutes intra-service time) which is an ultrasound guidance code that typically involves tissue sampling, and noted that the surveyed code is appropriately valued lower given it has less intra-service time and involves less intense physician work than the reference service. The RUC concluded that the value of CPT code 77002 should be maintained at 0.54 work RVUs as supported by the survey. **The RUC recommends a work RVU of 0.54 for CPT code 77002.**

77003 ***Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 82 physicians and determined that maintaining the current work RVU of 0.60, which falls below the survey 25th percentile, appropriately accounts for the physician work involved in this add-on service. The RUC recommends the following physician time components: 2 minutes pre-service positioning time, 15 minutes intra-service time, and 0 minutes post-service time.

CPT codes 77002 and 77003 were once XXX global period codes, but CMS determined that the vignettes and parentheticals for these codes were consistent with that of add-on codes and requested that the societies survey them as ZZZ codes in October 2015. At that time, the existing times for both 77002 and 77003 were 7 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service. At the October 2015 meeting, the RUC recommended reducing the pre-service time to 2 minutes instead of 7 minutes. The 2 minutes of pre-service time is based on the difference in pre-service positioning time between the epidural injection without imaging guidance (CPT code 62320) and with imaging guidance (CPT code 62321) codes. This is the reason why these add-on services include pre-service time.

The RUC compared CPT code 77003 to the top key reference code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU = 1.00, 10 minutes intra-service time) and noted that the surveyed code has more intra-service time but involves much less intense physician work and therefore is appropriately valued lower than the top key reference service which must target a smaller transforaminal approach compared

to the epidural or subarachnoid localization. The RUC also compared 77003 to the second highest key reference code 64491 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)* (work RVU = 1.16, 15 minutes intra-service time) and noted that the add-on codes have identical intra-service times, yet the surveyed code again involves less intense physician work and is appropriately valued lower than the reference service. The RUC concluded that the value of CPT code 77003 should be maintained at 0.60 work RVUs, below the 25th percentile of the survey. **The RUC recommends a work RVU of 0.60 for CPT code 77003.**

Affirmation of RUC Recommendations

The RUC reviewed the specialty societies' request to affirm the recent RUC valuations for the remaining codes in the Somatic Nerve Injections tab. Although these codes were identified with the other codes to be surveyed, the specialty societies elected not to survey because the codes were recently reviewed by the RUC and, unlike 64415-64417 and 64445-64448, there were no changes to their code descriptors. The RUC agreed to affirm the recommendations for the fourteen remaining codes. **The RUC recommends affirming the following recent RUC-recommended work RVUs:**

1.00 for CPT code 64400	**1.15 for CPT code 64430**
0.94 for CPT code 64405	**0.75 for CPT code 64435**
0.90 for CPT code 64408	**1.55 for CPT code 64449**
1.10 for CPT code 64418	**0.75 for CPT code 64450**
1.18 for CPT code 64420	**1.52 for CPT code 64451**
0.60 for CPT code 64421	**1.52 for CPT code 64454**
1.19 for CPT code 64425	**0.75 for CPT code 64455**

Practice Expense

Although not required due to the bundling of the codes, the specialty societies chose to address compelling evidence to support the direct practice expense recommendations. The Practice Expense (PE) Subcommittee discussed that these codes were previously reported without imaging and now include imaging, which constitutes the compelling evidence. It is the bundling of two codes into a single code. Further, the PE Subcommittee noted that the corresponding imaging code 76942 shows a net savings for each bundled code. The PE Subcommittee voted to approve compelling evidence for CPT codes 64415-64417 and 64445-64448. In addition, the PE Subcommittee verified the equipment minutes as submitted. The PE Subcommittee also voted to approve compelling evidence for CPT codes 76942, 77002 and 77003 to account for the updated calculation of equipment time for ED050 *Technologist PACS workstation* for CPT code 76942 and the addition of ED053 *Professional PACS workstation* for CPT codes 77002 and 77003. The previous omission of the Professional PACS workstation was in error. **The RUC recommends the direct practice expense inputs as submitted by the specialty society on all three PE spreadsheets.**

Potential Misreporting

For CPT codes 64445 and 64447, the RUC database indicates that family physicians are the dominant specialty in the non-facility setting, reporting at 36% and 57% respectively. The reporting of these services by family physicians was confusing since these are not procedures that would typically be provided by non-anesthesiologists. Upon further research, the specialties have determined that the family medicine non-facility reporting these services are likely a result of inappropriate reporting. The public 2019 Physician Supplier Procedure Summary (PSPS) file was

analyzed, and it was found that family medicine physicians in Fort Worth, Texas were responsible for 64% of all claims for CPT code 64445 and 89% of all claims for CPT code 64447. The large concentration of family medicine non-facility claims in one locality suggests potential misreporting. **The RUC suggests that CMS explore and address this misreporting.**

Work Neutrality
The RUC's recommendations for this CPT code set will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Category I **Surgery** **Nervous System** **Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System** **Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic** *For destruction by neurolytic agent or chemodenervation, see 62280-62282, 64600-64681) (For epidural or subarachnoid injection, see 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327) (64400-64455, 64461, 64462, 64463, 64479, 64480, 64483, 64484, 64490-64495 are unilateral procedures. For bilateral procedures, report 64400, 64405, 64408, 64415, 64416, 64417, 64418, 64420, 64425-64455, 64461, 64463, 64479, 64483, 64490, 64493 with modifier 50. Report add-on codes 64421, 64462, 64480, 64484, 64491, 64492, 64494, 64495 twice, when performed bilaterally. Do not report modifier 50 in conjunction with 64421, 64462, 64480, 64484, 64491, 64492, 64494, 64495)* **Somatic Nerves** *Codes 64400-64489 describe the introduction/injection of an anesthetic agent and/or steroid into the somatic nervous system for diagnostic or therapeutic purposes. For injection or destruction of genicular nerve branches, see 64454, 64624, respectively.* *Codes 64400-64450, 64454 describe the injection of an anesthetic agent(s) and/or steroid into a nerve plexus, nerve, or branch. These codes are reported once per nerve plexus, nerve, or branch as described in the descriptor regardless of the number of injections performed along the nerve plexus, nerve, or branch described by the code.* Imaging guidance and localization may be reported separately for 64400- 64405, 64408, 64420, 64421, 64425, 64430, 64435, 64449, 64450. Imaging guidance and any injection of contrast are inclusive components of 64415, 64416, 64417, 64445, 64446, 64447, 64448, 64451 and 64454. *Codes 64455, 64479, 64480, 64483, 64484 are reported for single or multiple injections on the same site. For 64479, 64480, 64483, 64484, imaging guidance (fluoroscopy or CT) and any injection of contrast are inclusive components and are not reported separately. For 64455, imaging guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately.*				

Codes 64461, 64462, 64463 describe injection of a paravertebral block (PVB). Codes 64486, 64487, 64488, 64489 describe injection of a transversus abdominis plane (TAP) block. Imaging guidance and any injection of contrast are inclusive components of 64461, 64462, 64463, 64486, 64487, 64488, 64489 and are not reported separately.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
(f)64400	M1	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	000	1.00 (Affirmed October 2018 RUC Recommendation)
(64402 has been deleted. To report injection of anesthetic agent and/or steroid to the facial nerve, use 64999)				
(f) 64405	M2	greater occipital nerve	000	0.94 (Affirmed April 2017 RUC Recommendation)
(f) 64408	M3	vagus nerve	000	0.90 (Affirmed October 2018 RUC Recommendation)
(64410, 64413 have been deleted. To report injection of anesthetic agent and/or steroid to the phrenic nerve, cervical plexus, use 64999)				
▲64415	M4	brachial plexus, including imaging guidance, when performed (Do not report 64415 in conjunction with 76942, 77002, 77003)	000	1.50
▲64416	M5	brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed (Do not report 64416 in conjunction with 01966, 76942, 77002, 77003)	000	1.80
▲64417	M6	axillary nerve, including imaging guidance, when performed (Do not report 64417 in conjunction with 76942, 77002, 77003)	000	1.31

(f)64418	M7	suprascapular nerve	000	1.10 (Affirmed April 2016 RUC Recommendation)
(f)64420	M8	intercostal nerve, single level	000	1.18 (Affirmed October 2018 RUC Recommendation)
(f)✚64421	M9	intercostal nerve, each additional level (List separately in addition to code for primary procedure) (Use 64421 in conjunction with 64420)	ZZZ	0.60 (Affirmed October 2018 RUC Recommendation)
(f)64425	M10	ilioinguinal, iliohypogastric nerves	000	1.19 (Affirmed October 2018 RUC Recommendation)
(f)64430	M11	pudendal nerve	000	1.15 (Affirmed October 2018 RUC Recommendation)
(f)64435	M12	paracervical (uterine) nerve	000	0.75 (No Change) (Affirmed October 2018 RUC Recommendation)
▲64445	M13	sciatic nerve, including imaging guidance, when performed (Do not report 64445 in conjunction with 76942, 77002, 77003)	000	1.39
▲64446	M14	sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed (Do not report 64446 in conjunction with 01966, 76942, 77002, 77003)	000	1.75

▲64447	M15	femoral nerve, including imaging guidance, when performed (Do not report 64447 in conjunction with 01966, 76942, 77002, 77003)	000	1.34
▲64448	M16	femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed (Do not report 64448 in conjunction with 01996, 76942, 77002, 77003)	000	1.68
(f)64449	M17	lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) (Do not report 64449 in conjunction with 01996)	000	1.55 (Affirmed October 2018 RUC Recommendation)
(f)64450	M18	other peripheral nerve or branch (For injection, anesthetic agent, nerves innervating the sacroiliac joint, use 64451)	000	0.75 (No Change) (Affirmed October 2018 RUC Recommendation)
(f)64451	M19	nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) (Do not report 64451 in conjunction with 64493, 64494, 64495, 77002, 77003, 77012, 95873, 95874) (For injection, anesthetic agent, nerves innervating the sacroiliac joint, with ultrasound, use 76999) (For bilateral procedure, report 64451 with modifier 50)	000	1.52 (No Change) (Affirmed February 2019 RUC Recommendation)
(f)64454	M20	genicular nerve branches, including imaging guidance, when performed (Do not report 64454 in conjunction with 64624) (64454 requires injecting all of the following genicular nerve branches: superolateral, superomedial, and inferomedial. If all 3 of these genicular nerve branches are not injected, report 64454 with modifier 52)	000	1.52 (No Change) (Affirmed February 2019 RUC Recommendation)

(f)64455	M21	plantar common digital nerve(s) (eg, Morton's neuroma) (Do not report 64455 in conjunction with 64632) (Imaging guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64479-64484. Imaging guidance and localization are required for the performance of 64479-64484)	000	0.75 (No Change) (Affirmed May 2017 RUC Recommendation)
(64470-64476 have been deleted. To report, see 64490- 64495)				
Radiology **Diagnostic Ultrasound** **Ultrasonic Guidance Procedures**				
(f)76942	M22	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation (Do not report 76942 in conjunction with 10004, 10005, 10006, 10021, 10030, 19083, 19285, 20604, 20606, 20611, 27096, 32408, 32554, 32555, 32556, 32557, 37760, 37761, 43232, 43237, 43242, 45341, 45342, 46948, 55874, 64415, 64416, 64417, 64445, 64446, 64447, 64448, 64479, 64480, 64483, 64484, 64490, 64491, 64493, 64494, 64495, 76975, 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0232T, 0481T, 0582T)	XXX	0.67 (No Change)
Radiologic Guidance **Fluoroscopic Guidance**				
(f) +77002	M23	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure) (Use 77002 in conjunction with 10160, 20206, 20220, 20225, 20520, 20525, 20526, 20550, 20551, 20552, 20553, 20555, 20600, 20605, 20610, 20612, 20615, 21116, 21550, 23350, 24220, 25246, 27093, 27095, 27369, 27648, 32400, 32553, 36002, 38220, 38221, 38222, 38505, 38794, 41019, 42400, 42405, 47000, 47001, 48102, 49180, 49411, 50200, 50390, 51100, 51101, 51102, 55700, 55876, 60100, 62268, 62269, 64400, 64405, 64408, ~~64415, 64416, 64417,~~ 64418, 64420, 64421, 64425, 64430, 64435 ~~64445, 64446, 64447, 64448,~~ 64450, 64455, 64505, 64600, 64605)	ZZZ	0.54 (No Change)

(f) ✚77003	M24	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure) (Use 77003 in conjunction with 61050, 61055, 62267, 62273, 62280, 62281, 62282, 62284, 64449, 64510, 64517, 64520, 64610, 96450) (Do not report 77003 in conjunction with 62270, 62272, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 62328, 62329, 64415, 64416, 64417, 64445, 64446, 64447, 64448, 0627T, 0628T)	ZZZ	0.60 (No Change)

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System			
Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic			
Code(s)	**Unit**	**~~Image~~ Imaging Guidance Included**	**~~Image~~ Imaging Guidance Separately Reported, When Performed**
Somatic Nerve			
64400 – 64408 ~~-64450~~	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X
64415 - 64417	1 unit per plexus, nerve, or branch injected regardless of the number of injections	X	
64418 - 64435	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X
64445 - 64448	1 unit per plexus, nerve, or branch injected regardless of the number of injections	X	
64449	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X
64450	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X

64451	1 unit for any number of nerves innervating the sacroiliac joint injected regardless of the number of injections	X	
64454	1 unit for any number of genicular nerve branches, with a required minimum of three nerve branches	X	
64455	1 or more injections per level		X
64479	1 or more injections per level	X	
+64480	1 or more additional injections per level (add-on)	X	
64483	1 or more injections per level	X	
+64484	1 or more additional injections per level (add-on)	X	
64461	1 injection site	X	
+64462	1 or more additional injections per code (add-on)	X	
64463	1 or more injections per code	X	
64486-64489	By injection site	X	
Destruction by Neurolytic Agent (Eg, Chemical, Thermal, Electrical, or Radiofrequency), Chemodenervation			
Code(s)	**Unit**	**~~Image~~ Imaging Guidance Included**	**~~Image~~ Imaging Guidance Separately Reported, When Performed**
Somatic Nerves			
64624	1 unit for any number of genicular nerve branches, with a required minimum of three nerve branches	X	

September 9, 2021

Ezequiel Silva III, MD
Chair, AMA/Specialty Society RVU Update Committee (RUC)
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

RE: Request to Reaffirm Physician Work and Practice Expense (PE) Recommendations for Select Codes from Tab 5: Somatic Nerve Injection (October 2021 RUC Meeting)

Dear Dr. Silva:

Tab 5 at the October 2021 RUC meeting consists of codes describing somatic nerve injection services and related imaging services. The procedures in this family are performed by several different specialties. Seven of the codes in the tab were revised at the May 2021 CPT meeting where imaging was bundled and these codes have been surveyed for the October 2021 RUC meeting (64415-64417, 64445-64448). Imaging codes related to this family were also surveyed for this meeting (77002, 77003, 76942).

As for the remaining codes in the tab, although these codes were identified with other codes to be surveyed, we elected not to survey because they have been recently reviewed by the RUC and unlike 64415-64417, 64445-64448; they did not have a change in their code descriptors. The below signed physician specialty societies request the RUC reaffirm their recommendations for these remaining codes.

Tab 5 Codes	
Surveyed for October 2021 RUC Meeting	• 64415-64417; 64445-64448* • 77002, 77003, 76942
Reaffirmation Requested	• 64400-64405, 64408 • 64418-64435 • 64449-64455

* Codes revised at May 2021 CPT meeting

Discussion on the reaffirmation of the wRVUs is below and PE recommendations on current PE forms have been submitted separately.

The societies would note that although all of these codes are under one tab, we do not believe these codes constitute a "family" in the traditional sense. For example, the services are provided by several different specialties. As such, rank order issues for these codes is not an issue. In addition, all these codes do not have imaging bundled into the code. Therefore rank order with the new codes (all with imaging bundled) is not an issue.

Recent History of Somatic Nerve Injection Code Family

These somatic nerve injection codes describes injection procedures using anesthetic agents or steroids. The procedures are performed by numerous different specialties, represented by the societies submitting this request to the RUC.

In May 2018, the CPT Editorial Panel reached out to the appropriate specialty societies requesting a code change application to provide further definition and descriptor transparency around the use of codes 64400-64455. The

updated language was approved at the May 2018 CPT Editorial Panel meeting and the majority of the codes were surveyed for the October 2018 RUC meeting. Exceptions to this include:

- Code 64405 was surveyed for the April 2017 RUC meeting and reaffirmed at the October 2018 RUC meeting.
- Code 64418 was surveyed for the April 2016 RUC meeting and reaffirmed at the October 2018 RUC meeting.
- CPT codes 64451 and 64454 were new codes established for the 2020 cycle and surveyed at the January 2019 RUC meeting.
- Code 64455 was surveyed for the April 2017 RUC meeting.

During the October 2018 RUC meeting, CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 were identified by the RUC to be reported with ultrasound imaging more than 50% of the time. The RUC referred these codes to CPT to be bundled with ultrasound guidance, CPT code 76942. The codes were revised at the May 2021 CPT meeting and surveyed for the October 2021 meeting.

A code-by code request with further details and identification of requesting societies follows.

64400

Requesting Societies*: ASA and AAN*

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64400	Oct. 2018	1.00	25th percentile of subset of respondents (AAN) and crosswalks	0.75

CPT code 64400 *(Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular))* was surveyed in October 2018 and the RUC recommended 1.00 wRVUs. Since the code was surveyed in 2018 and the new values were not established until 2020, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies recommend that the 2018 RUC recommended wRVU (1.00 wRVUs) and PE inputs for code 64400 be reaffirmed at the October 2021 RUC meeting.

Although CMS did not accept the RUC wRVU recommendation, the societies believe the most appropriate value to reaffirm is the RUC recommended value as it is based on known and appropriate valuation methods approved by the Committee.

The societies note that the code was flagged by the in the RUC Database as a code not to be used to value physician work. This flag was added during the 2018 survey process as the Committee recommended a wRVU value that was based onsurvey data from a subset of survey respondents. The joint societies believe the 2018 recommended wRVU value continues to appropriately describe the physician work being performed by physicians.

64405

Requesting Societies*: AAN, AAPM, AAPM&R and ASA*

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64405	Oct. 2018	0.94	Reaffirmed	0.94
	April 2017		Survey 25th percentile	

CPT code 64405 *(Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve)* was surveyed in October 2016 and the RUC recommended 0.94 wRVUs. 64405 was reaffirmed in October 2018. Since the code was surveyed in 2017 and reaffirmed in 2018, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies recommend that the 2018 RUC recommended wRVU (0.94 wRVUs) and PE inputs for code 64405 be reaffirmed at the October 2021 RUC meeting.

64408

Requesting Societies: AAO-HNS

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64408	Oct. 2018	0.90	25th percentile	0.75

CPT code 64408 *(Injection(s), anesthetic agent(s) and/or steroid; vagus nerve)* was surveyed in October 2018 and the RUC recommended 0.90 wRVUs. Since the code was surveyed in 2018 and the new values were not established until 2020, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The society recommends that the 2018 RUC recommended wRVU (0.90 wRVUs) and PE inputs for code 64408 be reaffirmed at the October 2021 RUC meeting.

Although CMS did not accept the RUC recommendation, the society believes the most appropriate value to reaffirm is the RUC recommended value as it is based on known and appropriate valuation methods approved by the Committee.

64418

Requesting Societies*: ASA, AAPM and AAPM&R*

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64418	Oct. 2018	1.10	Reaffirmed	1.10
	April 2016		Crosswalks	

CPT code 64418 (*Injection(s), anesthetic agent(s) and/or steroid; suprascapular nervewas)* was surveyed in October 2016 and the RUC recommended 1.10 wRVUs. 64418 was reaffirmed in October 2018. Since the code was surveyed in 2016 and reaffirmed in 2018, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies recommend that the 2018 RUC recommended wRVU (1.10 wRVUs) and PE inputs for code 64418 be reaffirmed at the October 2021 RUC meeting.

64420

Requesting Societies*: ASA, AAPM and AAPM&R*

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64420	Oct. 2018	1.18	Existing value with crosswalks	1.08

CPT code 64420 *(Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level)* was surveyed in October 2018 and was valued by the RUC at 1.18 wRVUs. Since the code was surveyed in 2018, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies therefore recommend that the 2018 RUC recommended wRVU (1.18 wRVUs) and PE inputs for code 64420 be reaffirmed at the October 2021 RUC meeting.

Although CMS did not accept the RUC recommendation, the societies believe the most appropriate value to reaffirm is the RUC recommended value as it is based on known and appropriate valuation methods approved by the Committee.

64421

Requesting Societies: ***ASA, AAPM and AAPM&R***

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64421	Oct. 2018	0.60	Crosswalk	0.50

CPT code 64421 *(Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedure))* was surveyed in October 2018 and the RUC recommended 0.60 wRVUs. Since the code was restricted to be an add-on code and was surveyed in 2018, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies therefore recommend that the 2018 RUC recommended wRVU (0.60 wRVUs) and PE inputs for code 64421 be reaffirmed at the October 2021 RUC meeting.

Although CMS did not accept the RUC recommendation, the societies believe the most appropriate value to reaffirm is the RUC recommended value as it is based on known and appropriate valuation methods approved by the Committee.

64425

Requesting Societies: ***ASA, AAPM and AAPM&R***

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64425	Oct. 2018	1.19	Survey 25th percentile	1.00

CPT code 64425 *(Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves)* was surveyed in October 2018 and the RUC recommended 1.19 wRVUs. Since the code was surveyed in 2018, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies therefore recommend that the 2018 RUC recommended wRVU (1.19 wRVUs) and PE inputs for code 64425 be reaffirmed at the October 2021 RUC meeting.

Although CMS did not accept the RUC recommendation, the societies believe the most appropriate value to reaffirm is the RUC recommended value as it is based on known and appropriate valuation methods approved by the Committee.

64430

Requesting Societies*: ACOG, ASA and AAPM*

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64430	Oct. 2018	1.15	Survey 25th percentile	1.00

CPT code 64430 *(Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve)* was surveyed in October 2018 and the RUC recommended 1.15 wRVUs. Since the code was surveyed in 2018, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies therefore recommend that the 2018 RUC recommended wRVU (1.15 wRVUs) and PE inputs for code 64430 be reaffirmed at the October 2021 RUC meeting.

Although CMS did not accept the RUC recommendation, the societies believe the most appropriate value to reaffirm is the RUC recommended value as it is based on known and appropriate valuation methods approved by the Committee.

64435

Requesting Societies: ***ACOG***

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64435	Oct. 2018	0.75	Survey 25th percentile	0.75

CPT code 64435 *(Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve)* was surveyed in October 2018 and the RUC recommended 0.75 wRVUs. Since the code was surveyed in 2018, the representing society does not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The society therefore recommends that the 2018 RUC recommended wRVU (0.75 wRVUs) and PE inputs for code 64435 be reaffirmed at the October 2021 RUC meeting.

64449

Requesting Societies*: ASA*

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64449	Oct. 2018	1.55	Crosswalk	1.27

CPT code 64449 (*Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement))* was surveyed in October 2018 and the RUC recommended 1.55 wRVUs. Since the code was surveyed in 2018, the representing society does not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The society therefore recommends that the 2018 RUC recommended wRVU (1.55 work RVU) and PE inputs for code 64449 be reaffirmed at the October 2021 RUC meeting.

Although CMS did not accept the RUC recommendation, the societies believe the most appropriate value to reaffirm is the RUC recommended value as it is based on known and appropriate valuation methods approved by the Committee.

64450

Requesting Societies: ASA, AAPM, AAN, and AAPM&R

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64450	Oct. 2018	0.75	Current value and crosswalks	0.75

CPT code 64450 (*Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch))* was surveyed in October 2018 and the RUC recommended 0.75 wRVUs. Since the code was surveyed in 2018, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies therefore recommend that the 2018 RUC recommended wRVU (0.75 wRVUs) and PE inputs for code 64450 be reaffirmed at the October 2021 RUC meeting.

64451

Requesting Societies: ASA, AAPM, AAPM&R, SIS, ASIPP and NANS

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64451	Jan. 2019	1.52	Survey 25th percentile	1.52

CPT code 64451 (*Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography))* was surveyed in January 2019 and the RUC recommended 1.52 wRVUs. Since the code was new to CPT 2020 and surveyed in 2019, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies therefore recommend that the 2019 RUC recommended wRVU (1.52 wRVUs) and PE inputs for code 64451 be reaffirmed at the October 2021 RUC meeting.

64454

***Requesting Societies*: ASA, AAPM, AAPM&R, ASIPP and SIS**

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64454	Jan. 2019	1.52	Survey 25th percentile	1.52

CPT code 64454 (*Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed*) was surveyed in January 2019 and the RUC recommended 1.52 wRVUs. Since the code was new to CPT 2020 and surveyed in 2019, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies therefore recommend that the 2019 RUC recommended wRVU (1.52 wRVUs) and PE inputs for code 64451 be reaffirmed at the October 2021 RUC meeting.

64455

Requesting Societies: APMA

Code	RUC Meeting	RUC wRVU Rec.	RUC Rationale	2021 wRVU
64455	April. 2017	0.75	Current value and crosswalks	0.75

CPT code 64455 (*Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma))* was surveyed in April 2017 and the RUC recommended 0.75 wRVUs. Since the code was surveyed in 2017, the representing societies do not believe enough time has lapsed for there to be sufficient utilization data to assess if resurvey is necessary.

The joint societies therefore recommend that the 2017 RUC recommended wRVU (0.75 wRVUs) and PE inputs for code 64455 be reaffirmed at the October 2021 RUC meeting.

Table 1. Summary of Reaffirmation Recommendations

Code	Descriptor	Societies' Recommended Reaffirmation Values (RUC Recommended Values)
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	1.00
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	0.94
64408	Injection(s), anesthetic agent(s) and/or steroid; vagus nerve	0.90
64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	1.10
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	1.18
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedure)	0.60
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	1.19
64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve	1.15
64435	Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve	0.75
64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	1.55
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	0.75

Code	Descriptor	Societies' Recommended Reaffirmation Values (RUC Recommended Values)
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	1.52
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	1.52
64455	Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)	0.75

We look forward to presenting our recommendation for the Somatic Nerve Injection code set at the upcoming RUC meeting. If you have any questions, please contact ASA staff Sharon Merrick, s.merrick@asahq.org, ASA Consultant Sheila Madhani, smadhani@mcdermottplus.com, or AAPM&R staff Carolyn Winter-Rosenberg, cwinterrosenberg@aapmr.org.

Thank you for your consideration of this request.

Sincerely,

/s/
AAN RUC Advisor

AAO-HNS RUC Advisor

AAPM RUC Advisor

AAPM&R RUC Advisor

ACOG RUC Advisor

APMA RUC Advisor

ASA RUC Advisor

ASIPP RUC Advisor

NANS RUC Advisor

SIS RUC Advisor

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64415 Tracking Number Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.50**
Global Period: 000 Current Work RVU: **1.35** RUC Recommended RVU: **1.50**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year-old female will undergo surgery on her shoulder and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A brachial plexus block with ultrasound guidance is performed to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The anesthesiologist obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The anesthesiologist communicates with surgeon to confirm that a block is indicated for postoperative pain management, confirms that the surgical consent is complete and the surgeon has seen the patient, and confirms that the surgical site is marked per institutional protocol. The anesthesiologist inspects and prepares the ultrasound equipment, including appropriate transducers, needle guides if applicable, and probe covers, as well as the proper settings for the ultrasound equipment. The anesthesiologist obtains informed consent. The site of the proposed procedure is marked. The patient is monitored in a procedure room or operating room. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the brachial plexus are identified and with ultrasound imaging, the nerve(s) are visualized, and the skin entry point is identified. A local anesthetic skin wheal is created. Under ultrasound guidance, a needle is advanced towards the brachial plexus and correct position is confirmed. Under continuous ultrasound imaging, a local anesthetic solution with or without adjuvants is injected into the fascial compartment containing the brachial plexus using intermittent aspiration and injection. The needle is removed. After cleaning of site, and occlusive dressing is placed.

Description of Post-Service Work: Observe the patient for any signs or symptoms of local anesthetic systemic toxicity. After several minutes have passed, evaluate the initial effects of the brachial plexus nerve block by physical examination to determine if the patient is developing appropriate weakness, numbness, and relief of pain in the expected nerve distribution. A procedure note is entered into the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	ASA: Richard Rosenquist, MD; Neal Cohen, MD; Gordon Morewood, MD ASIP: Michael Lubrano, MD					
Specialty Society(ies):	ASA, ASIPP					
CPT Code:	64415					
Sample Size:	4393	**Resp N:**	86			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	18.00	**48.00**	119.00	550.00	
Survey RVW:	0.90	1.50	**1.80**	2.00	5.00	
Pre-Service Evaluation Time:			**17.00**			
Pre-Service Positioning Time:			**4.00**			
Pre-Service Scrub, Dress, Wait Time:			**4.00**			
Intra-Service Time:	3.00	6.00	**10.00**	15.00	180	
Immediate Post Service-Time:	**7.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	_____	99291x	99292x			
Other Hospital time/visit(s):	_____	99231x	99232x	99233x		
Discharge Day Mgmt:	_____	99238x	99239x	99217x		
Office time/visit(s):	_____	99211x	12x	13x	14x	15x
Prolonged Services:	_____	99354x	55x	56x	57x	
Sub Obs Care:	_____	99224x	99225x	99226x		

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64415	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**4.00**	**6.00**	**-2.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**7.00**	**18.00**	**-11.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20611	000	1.10	**RUC Time**	1,069,935

CPT Descriptor 1 Arthrocentresis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,044,547

CPT Descriptor 2 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
64488	000	1.60	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 **% of respondents:** 33.7 **%**

Number of respondents who choose 2nd Key Reference Code: 25 **% of respondents:** 29.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 64415	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: 62323
Median Pre-Service Time	18.00	15.00	20.00
Median Intra-Service Time	10.00	10.00	15.00
Median Immediate Post-service Time	7.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**35.00**	**35.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	34%	48%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	52%	48%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	45%	55%
Physical effort required	7%	79%	14%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	21%	76%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	12%	72%	12%	4%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	21%	62%	17%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	60%	36%
Physical effort required	4%	67%	29%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	60%	20%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Last surveyed at the October 2018 RUC meeting, the current codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 describe only injection of an anesthetic agent in the area of the peripheral nerve and/or catheter placement for postoperative pain management after surgery BUT do not include imaging guidance. The imaging guidance was reported using 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*). In October 2018 the RUC identified that over 50% of the time codes 64415-64417 and 64446-64448 were reported with ultrasound imaging code

over 76942 The RUC referred these codes to the CPT Editorial Panel indicating they need to be bundled with imaging guidance. Although 644445 was not part of the original application, in reviewing billed together data as part of its work for submitting the CPT application, the American Society of Anesthesiologists (ASA) found that the 2021 RUC database indicated that 64445 is billed with code 76942 65.4% of the time. As a result, ASA included 64445 in its CPT application submission.

Therefore, the surveyed codes are new codes that describe both work of the injection with or without a catheter placement AND imaging guidance.

When imaging is provided, ultrasound described by code 76942 is the dominant imaging modality for all of codes.

Code	Percent CPT Code Billed with 76942 (2019)
64415	86.8%
64416	88.1%
64417	78.5%
64445	68.8%
64446	83.3%
64447	87.3%
64448	87.0%

Source: 2021 RUC Database

At their May 2021 meeting, the CPT Editorial Panel approved new descriptors for codes 64415-54417 and 6445-64448 where managing was bundled. ASA and the American Society of Interventional Pain Physicians (ASIPP) surveyed these codes for the October 2021 RUC meeting.

Summary of Recommendations for Codes 64415-64417 and 64445-64448

Code#	Description	Oct 2018 RUC Recommended Work Value Injection Code Only	Current (CMS) Work RVU Injection Code Only	Current Work RVU Injection Combined with Imaging (76942)	October 2021 Recommendation of New Codes with Imaging bundled	October 2021 Recommendation Rationale
64415	Brachial Plexus Injection only	1.42	1.35	2.02	**1.50**	Survey 25th percentile
64416	Brachial Plexus Injection and Catheter	1.81	1.48	2.15	**1.80**	Survey 25th percentile
64417	Axillary Nerve Injection only	1.27	1.27	1.94	**1.31**	Survey 25th percentile
64445	Sciatic Nerve Injection only	1.18	1.00	1.67	**1.39**	Survey 25th percentile
64446	Sciatic Nerve Injection and Catheter	1.54	1.36	2.03	**1.75**	Survey 25th percentile
64447	Femoral Nerve Injection only	1.10	1.10	1.77	**1.34**	Survey 25th percentile
64448	Femoral Nerve Injection and Catheter	1.55	1.41	2.08	**1.68**	Survey 25th percentile

Recommended Values and Relativity within the Family

- Injection Only Codes. The current survey recommended wRVU (25th percentile of survey) is generally consistent with the 2018 RUC recommended wRVU demonstrating that the Brachial Plexus injection (64415) is more work and higher wRVU than the other injection codes. In addition, the other three injection only codes (64417, 64445, 64447) have similar wRVUs in both the 2018 RUC recommended wRVU and the current survey recommended wRVU.

- Additional work for catheter placement. The current survey recommended wRVU and the 2018 RUC recommended wRVU maintain relativity with the injection only codes. The current survey recommended values show an incremental increase in wRVU of 0.30-0.36 units and the 2018 RUC recommended values had an incremental increase in wRVU of 0.31-0.45 units. Further, the additional time for the catheter placement is 5-7 min in the current survey is consistent with the 2018 RUC survey that had additional time for catheter placement of 5-8 min.

CODE 64415

64415 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed

Survey Description

ASA and ASIPP conducted a random survey of 4,393 members (4,093 ASA members and 300 ASIPP members). A total of 86 responses were received (85 ASA members and 1 ASIPP member). The median experience in the previous 12 months for all respondents was 48.

Recommendation – 64415

64415 – Recommendation Summary	
Work RVU	1.50 (survey 25th)
Physician Time	
Pre-Time	13/1/4
Intra-Time	10
Immediate Post Time	7
Total Time	35

Work RVU

The Survey median Work RVU was 1.80 and the survey 25th percentile was 1.50.

- We recommend the 25th percentile of 1.50.

This recommendation is less than current combined Work RVU of 64415 and 76942 which is 2.02 (1.35 + 0.67 = 2.02 Work RVUs).

Physician Time

Pre-Service Package: 1 (with 2 minute reduction for scrub/dress/wait)

Evaluation: 13 minutes

Positioning: 1

SDW: 4

Intra-Service Time: 10 minutes

Immediate Post Service: 7 minutes

Total Time: 35 minutes

Framework for Considering Time and Intensity When Imaging Is Bundled

In selecting the 25th percentile, the societies considered how time and intensity should be considered. They noted that it was important to compare the recommendation to not just the current injection code alone but compare it to the combined injection and imaging code.

Time

The societies noted that for 64415 intra-time did decrease by two minutes. They discussed that in general when surveying this code with imaging now bundled they would not expect the intra-time to increase significantly because for the majority of the intra-time the imaging and the injection physician work is occurring simultaneously.

Breakdown of Physician Work for Code 64415	
	Intra-service Time

Type of Physician Work	
Ultrasound Imaging	⟷
Injection	⟷

Intensity

Similar to thinking about time, the societies considered that intensity of the new surveyed code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the new code describes the physician work of doing both the injection and imaging simultaneously where in the older code only describes the physician work of doing only the injection alone. In reviewing the intensities, the societies concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

Source	CPT	IWPUT	Work RVU	Total Time	Pre-Time Evaluation	Pre-Time Positioning	Pre-Time SDW	Intra	Post
Current	64415	0.065	1.35	40	13	1	4	12	10
Current	76942	0.027	0.67	27	7	0	0	15	5
Current – Combined*	64415 + 76942	0.097	2.02	43	13	1	4	15	10
Recommendation	64415	0.100	1.50	35	13	1	4	10	7

*Combined intra time reflects efficiencies between CPT 64415 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64415 and 76942.

Key Reference Service (KRS) Code Comparison

The societies then compared the surveyed code to the top KRS codes and found that they provided further support that the recommendation was appropriate.

KRS1: The most typical KRS selected was CPT code 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed*)) with 33.72% respondents selecting this code. Over 50% of the survey respondents that selected this KRS indicated that the surveyed code was more intense.

KRS2: The second most typical KRS selected was CPT code 62323 (*Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)*) with 29.0% of the respondents selecting this code. 88% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed	1.27	0.078	35	15	10	10
64415	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed**	**1.50**	**0.100**	**35**	**18**	**10**	**7**
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	1.80	0.080	45	20	15	10

MPC Codes

Our recommended Work RVU of 1.50 is well bracketed by MPC codes with the similar intra-service time and similar total times and clinically similar and with similar intensities. The two MPC codes are code 20611 with a Work RVU of 1.10 and code 64483 with a Work RVU of 1.90.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	1.10	0.0791	27	12	10	5
64415	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed**	**1.50**	**0.100**	**35**	**18**	**10**	**7**
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	1.90	0.0816	49	24	15	10

Other Code Comparison

Societies also reviewed how the recommendation fit in with other codes with similar intra-service time, similar total time, clinically similar and with similar intensities and concluded that this provided further evidence of the appropriateness of the recommendation.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	1.48	0.0861	38	17	11	10
64415	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed**	**1.50**	**0.100**	**35**	**18**	**10**	**7**
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)	1.60	0.0741	40	15	15	10

Summary

The societies recommend for code 64415 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed*) the following:

Work RVU: 1.50 (25th percentile)

Physician Time

- Pre-Time: 13/1/4 minutes
- Intra-Service Time: 10 minutes
- Post Time: 7 minutes
- Total Time: 35 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64415

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNAs How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 597450
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization.

Specialty Anesthesiology Frequency 523964 Percentage 87.70 %

Specialty CRNAs Frequency 60342 Percentage 10.09 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 199,150 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Anesthesiology Frequency 174655 Percentage 87.70 %

Specialty CRNAs Frequency 20114 Percentage 10.09 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64415

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64416 Tracking Number Original Specialty Recommended RVU: **1.80**
Presented Recommended RVU: **1.80**
Global Period: 000 Current Work RVU: **1.48** RUC Recommended RVU: **1.80**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old female will undergo surgery on her shoulder and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A brachial plexus block with a catheter and a continuous infusion of local anesthetic with ultrasound guidance is performed to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The anesthesiologist obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The anesthesiologist communicates with surgeon to confirm that a block is indicated for postoperative pain management, confirms that the surgical consent is complete and the surgeon has seen the patient, and confirms that the surgical site is marked per institutional protocol. The anesthesiologist inspects and prepares the ultrasound equipment, including appropriate transducers, needle guides if applicable, and probe covers, as well as the proper settings for the ultrasound equipment. The anesthesiologist obtains informed consent. The site of the proposed procedure is marked. The patient is monitored in a procedure room or operating room. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the brachial plexus are identified and with ultrasound imaging, the nerve(s) are visualized, and the skin entry point is identified. A local anesthetic skin wheal is created. Under ultrasound guidance, a needle is advanced towards the brachial plexus and correct position is confirmed. Under continuous ultrasound imaging a local anesthetic or crystalloid solution is injected into the fascial compartment containing the brachial plexus using intermittent aspiration and injection. A catheter is advanced carefully under ultrasound guidance to lie next to the brachial plexus then the needle is removed. Local anesthetic is injected via the catheter. The catheter is secured and an occlusive dressing is placed.

Description of Post-Service Work: Observe the patient for any signs or symptoms of local anesthetic systemic toxicity. After several minutes have passed, evaluate the initial effects of the brachial plexus nerve block by physical examination to determine if the patient is developing appropriate weakness, numbness, and relief of pain in the expected nerve distribution. A procedure note is entered into the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	ASA: Richard Rosenquist, MD; Neal Cohen, MD; Gordon Morewood, MD ASIPP: Michael Lubrano, MD					
Specialty Society(ies):	ASA, ASIPP					
CPT Code:	64416					
Sample Size:	4393	**Resp N:**	79			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**10.00**	28.00	400.00	
Survey RVW:	1.00	1.80	**2.00**	2.20	6.00	
Pre-Service Evaluation Time:			**20.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**5.00**			
Intra-Service Time:	0.00	12.00	**15.00**	20.00	180.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	64416	**Recommended Physician Work RVU: 1.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**18.00**	**-5.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62325	000	2.20	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62327	000	1.90	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20611	000	1.10	**RUC Time**	1,069,935

CPT Descriptor 1 Arthrocentresis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,044,547

CPT Descriptor 2 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
64479	000	2.29	**RUC Time**

CPT Descriptor Injection(s), anesthetic agent(s) and/or steriod; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 28 **% of respondents:** 35.4 **%**

Number of respondents who choose 2nd Key Reference Code: 27 **% of respondents:** 34.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 64416	Top Key Reference CPT Code: 62325	2nd Key Reference CPT Code: 62327
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	15.00	15.00	15.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**44.00**	**45.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	64%	25%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	71%	22%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	50%	50%
Physical effort required	0%	63%	37%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	53%	36%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	70%	15%	4%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	15%	59%	26%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	63%	33%
Physical effort required	0%	74%	26%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	67%	22%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Last surveyed at the October 2018 RUC meeting, the current codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 describe only injection of an anesthetic agent in the area of the peripheral nerve and/or catheter placement for postoperative pain management after surgery BUT do not include imaging guidance. The imaging guidance was reported using 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*). In October 2018 the RUC identified that over 50% of the time codes 64415-64417 and 64446-64448 were reported with ultrasound imaging code over 76942 The RUC referred these codes to the CPT Editorial Panel indicating they need to be bundled with imaging guidance. Although 644445 was not part of the original application, in reviewing billed together data as part of its work for submitting the CPT application, the American Society of Anesthesiologists (ASA) found that the 2021 RUC database indicated that 64445 is billed with code 76942 65.4% of the time. As a result ASA included 64445 in its CPT application submission.

Therefore, the surveyed codes are new codes that describe both work of the injection with or without a catheter placement AND imaging guidance.

When imaging is provided, ultrasound described by code 76942 is the dominant imaging modality for all of codes.

Code	Percent CPT Code Billed with 76942 (2019)
64415	86.8%
64416	88.1%
64417	78.5%
64445	68.8%
64446	83.3%
64447	87.3%
64448	87.0%

Source: 2021 RUC Database

At their May 2021 meeting, the CPT Editorial Panel approved new descriptors for codes 64415-54417 and 6445-64448 where managing was bundled. ASA and the American Society of Interventional Pain Physicians (ASIPP) surveyed these codes for the October 2021 RUC meeting.

Summary of Recommendations for Codes 64415-64417 and 64445-64448

Code #	Description	Oct 2018 RUC Recommended Work Value Injection Code Only	Current (CMS) Work RVU Injection Code Only	Current Work RVU Injection Combined with Imaging (76942)	October 2021 Recommendation of New Codes with Imaging bundled	October 2021 Recommendation Rationale
64415	Brachial Plexus Injection only	1.42	1.35	2.02	**1.50**	Survey 25th percentile
64416	Brachial Plexus Injection and Catheter	1.81	1.48	2.15	**1.80**	Survey 25th percentile
64417	Axillary Nerve Injection only	1.27	1.27	1.94	**1.31**	Survey 25th percentile
64445	Sciatic Nerve Injection only	1.18	1.00	1.67	**1.39**	Survey 25th percentile
64446	Sciatic Nerve Injection and Catheter	1.54	1.36	2.03	**1.75**	Survey 25th percentile
64447	Femoral Nerve Injection only	1.10	1.10	1.77	**1.34**	Survey 25th percentile
64448	Femoral Nerve Injection and Catheter	1.55	1.41	2.08	**1.68**	Survey 25th percentile

Recommended Values and Relativity within the Family

- Injection Only Codes. The current survey recommended wRVU (25th percentile of survey) is generally consistent with the 2018 RUC recommended wRVU demonstrating that the Brachial Plexus injection (64415) is more work and higher wRVU than the other injection codes. In addition, the other three injection only codes (64417, 64445, 64447) have similar wRVUs in both the 2018 RUC recommended wRVU and the current survey recommended wRVU.
- Additional work for catheter placement. The current survey recommended wRVU and the 2018 RUC recommended wRVU maintain relativity with the injection only codes. The current survey recommended values show an incremental increase in wRVU of 0.30-0.36 units and the 2018 RUC recommended values had an incremental increase in wRVU of 0.31-0.45 units. Further, the additional time for the catheter placement is 5-7 min in the current survey is consistent with the 2018 RUC survey that had additional time for catheter placement of 5-8 min.

CODE 64416

64416 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed

Survey Description

ASA and ASIPP conducted a random survey of 4,393 members (4,093 ASA members and 300 ASIPP members). A total of 79 responses were received (78 ASA members and 1 ASIPP member). The median experience in the previous 12 months for all respondents was 10.

Recommendation – 64416

64416 – Recommendation Summary	
Work RVU	1.80 (survey 25th)
Physician Time	
Pre-Time	13/1/5
Intra-Time	15
Immediate Post Time	10
Total Time	44

Work RVU

The Survey median Work RVU was 2.00 and the survey 25th percentile was 1.80.

- We recommend the 25th percentile of 1.80.

This recommendation is less than current combined Work RVU of 64416 and 76942 which is 2.15 (1.48 + 0.67 = 2.15 Work RVUs).

Physician Time

Pre-Service Package: 2 (1 minute deducted from scrub, dress and wait)

Evaluation: 13 minutes

Positioning: 1

SDW: 5

Intra-Service Time: 15 minutes

Immediate Post Service: 10 minutes

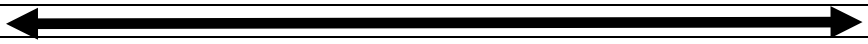
Total Time: 44 minutes

Framework for Considering Time and Intensity When Imaging Is Bundled

In selecting the 25th percentile, the societies considered how time and intensity should be considered. They noted that it was important to compare the recommendation to not just the current injection code alone but compare it to the combined injection and imaging code.

Time

The societies noted that for 64416 intra-time did decrease by five minutes. They discussed that in general when surveying this code with imaging now bundled they would not expect the intra-time to increase significantly because for the majority of the intra-time the imaging and the injection physician work is occurring simultaneously.

Breakdown of Physician Work for Code 64416	
	Intra-service Time
Type of Physician Work	
Ultrasound Imaging	
Catheter Placement and Injection	

Intensity

Similar to thinking about time, the societies considered that intensity of the new surveyed code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the new code describes the physician work of doing both the injection and imaging simultaneously where in the older code only describes the physician work of doing only the injection alone. In reviewing the intensities, the societies concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

Source	**CPT**	**IWPUT**	**Work RVU**	**Total Time**	**Pre-Time Evaluation**	**Pre-Time Positioning**	**Pre-Time SDW**	**Intra**	**Post**
Current	64416	0.045	1.48	49	13	1	5	20	10
Current	76942	0.027	0.67	27	7	0	0	15	5
Current – Combined*	64416 + 76942	0.068	2.15	52	13	1	5	23	10
Recommendation	64416	0.081	1.80	44	13	1	5	15	10

*Combined intra time reflects efficiencies between CPT 64416 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64416 and 76942.

Key Reference Service (KRS) Code Comparison

The societies then compared the surveyed code to the top KRS codes and found that they provided further support that the recommendation was appropriate.

KRS1: The most typical KRS selected was CPT code 62325 (*Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT*)) with 35.44% respondents selecting this code. 96% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

KRS2: The second most typical KRS selected was CPT code 62327 (*Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)*) with 34.18% of the respondents selecting this code. 89% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

CPT	**DESCRIPTOR**	**RVW**	**IWPUT**	**TOTAL TIME**	**PRE**	**INTRA**	**POST**
64416	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed**	**1.80**	**0.081**	**44**	**19**	**15**	**10**
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	1.90	0.0866	45	20	15	10

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	2.20	0.1066	45	20	15	10

MPC Codes

Our recommended Work RVU of 1.80 is well bracketed by MPC codes with the similar intra-service time and similar total times and clinically similar and with similar intensities. The two MPC codes are code 20611 with a Work RVU of 1.10 and code 64483 with a Work RVU of 1.90.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	1.10	0.0791	27	12	10	5
64416	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed**	**1.80**	**0.081**	**44**	**19**	**15**	**10**
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	1.90	0.0816	49	24	15	10

Other Code Comparison

Societies also reviewed how the recommendation fit in with other codes with similar intra-service time, similar total time, clinically similar and with similar intensities and concluded that this provided further evidence of the appropriateness of the recommendation.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)	1.60	0.0741	40	15	15	10
64416	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed**	**1.80**	**0.081**	**44**	**19**	**15**	**10**
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level	2.29	0.1076	49	24	15	10

Summary

The societies recommend for code 64416 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed*) the following:

Work RVU: 1.80 (25th percentile)

Physician Time

- Pre-Time: 13/1/5 minutes
- Intra-Service Time: 15 minutes
- Post Time: 10 minutes
- Total Time: 44 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64416

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNAs How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 53736
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 48953 Percentage 91.09 %

Specialty CRNAs Frequency 3869 Percentage 7.20 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 17,912 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Anesthesiology Frequency 16318 Percentage 91.10 %

Specialty CRNAs Frequency 1290 Percentage 7.20 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64416

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64417 Tracking Number Original Specialty Recommended RVU: **1.31**
Presented Recommended RVU: **1.31**
Global Period: 000 Current Work RVU: **1.27** RUC Recommended RVU: **1.31**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male will undergo surgery on his arm and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. An axillary nerve block with ultrasound guidance is performed to relieve his pain and improve his function.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The anesthesiologist obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The anesthesiologist communicates with surgeon to confirm that a block is indicated for postoperative pain management, confirms that the surgical consent is complete and the surgeon has seen the patient, and confirms that the surgical site is marked per institutional protocol.The anesthesiologist inspects and prepares the ultrasound equipment, including appropriate transducers, needle guides if applicable, and probe covers, as well as the proper settings for the ultrasound equipment. The anesthesiologist obtains informed consent. The site of the proposed procedure is marked. The patient is monitored in a procedure room or operating room. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the axillary nerve are identified and with ultrasound imaging, the nerve(s) are visualized, and the skin entry point is identified. A local anesthetic skin wheal is created. Under ultrasound guidance, a needle is advanced towards the target nerve(s) and correct position is confirmed. A local anesthetic solution with or without adjuvants is injected around the target nerve using intermittent aspiration and injection. The needle is removed. After cleaning of site, and occlusive dressing is placed.

Description of Post-Service Work: Observe the patient for any signs or symptoms of local anesthetic systemic toxicity. After several minutes have passed, evaluate the initial effects of the axillary nerve block by physical examination to determine if the patient is developing appropriate weakness, numbness, and relief of pain in the expected nerve distribution. A procedure note is entered into the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	ASA: Richard Rosenquist, MD; Neal Cohen, MD; Gordon Morewood, MD ASIPP: Michael Lubrano, MD					
Specialty Society(ies):	ASA, ASIPP					
CPT Code:	64417					
Sample Size:	4393	**Resp N:**	79			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**10.00**	50.00	550.00	
Survey RVW:	0.90	1.31	**1.60**	1.90	5.00	
Pre-Service Evaluation Time:			**18.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**4.00**			
Intra-Service Time:	3.00	7.00	**10.00**	15.00	180.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64417	**Recommended Physician Work RVU: 1.31**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**4.00**	**6.00**	**-2.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20611	000	1.10	**RUC Time**	1,069,935

CPT Descriptor 1 Arthrocentresis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,044,547

CPT Descriptor 2 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transverus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 **% of respondents:** 36.7 **%**

Number of respondents who choose 2nd Key Reference Code: 18 **% of respondents:** 22.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 64417	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: **62323**
Median Pre-Service Time	18.00	15.00	20.00
Median Intra-Service Time	10.00	10.00	15.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**38.00**	**35.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	48%	41%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	59%	41%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	62%	38%
Physical effort required	7%	79%	14%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	41%	52%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	83%	6%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	29%	53%	18%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	61%	28%
Physical effort required	6%	71%	23%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	22%	67%	11%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Last surveyed at the October 2018 RUC meeting, the current codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 describe only injection of an anesthetic agent in the area of the peripheral nerve and/or catheter placement for postoperative pain management after surgery AND do not include imaging guidance. The imaging guidance was reported using 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*). In October 2018 the RUC identified that over 50% of the time codes 64415-64417 and 64446-64448 were reported with ultrasound imaging code

over 76942 The RUC referred these codes to the CPT Editorial Panel indicating they need to be bundled with imaging guidance. Although 644445 was not part of the original application, in reviewing billed together data as part of its work for submitting the CPT application, the American Society of Anesthesiologists (ASA) found that the 2021 RUC database indicated that 64445 is billed with code 76942 65.4% of the time. As a result ASA included 64445 in its CPT application submission.

Therefore, the surveyed codes are new codes that describe both work of the injection with or without a catheter placement AND imaging guidance.

When imaging is provided, ultrasound described by code 76942 is the dominant imaging modality for all of codes.

Code	Percent CPT Code Billed with 76942 (2019)
64415	86.8%
64416	88.1%
64417	78.5%
64445	68.8%
64446	83.3%
64447	87.3%
64448	87.0%

Source: 2021 RUC Database

At their May 2021 meeting, the CPT Editorial Panel approved new descriptors for codes 64415-54417 and 6445-64448 where managing was bundled. ASA and the American Society of Interventional Pain Physicians (ASIPP) surveyed these codes for the October 2021 RUC meeting.

Summary of Recommendations for Codes 64415-64417 and 64445-64448

Code#	Description	Oct 2018 RUC Recommended Work Value Injection Code Only	Current (CMS) Work RVU Injection Code Only	Current Work RVU Injection Combined with Imaging (76942)	October 2021 Recommendation of New Codes with Imaging bundled	October 2021 Recommendation Rationale
64415	Brachial Plexus Injection only	1.42	1.35	2.02	**1.50**	Survey 25th percentile
64416	Brachial Plexus Injection and Catheter	1.81	1.48	2.15	**1.80**	Survey 25th percentile
64417	Axillary Nerve Injection only	1.27	1.27	1.94	**1.31**	Survey 25th percentile
64445	Sciatic Nerve Injection only	1.18	1.00	1.67	**1.39**	Survey 25th percentile
64446	Sciatic Nerve Injection and Catheter	1.54	1.36	2.03	**1.75**	Survey 25th percentile
64447	Femoral Nerve Injection only	1.10	1.10	1.77	**1.34**	Survey 25th percentile
64448	Femoral Nerve Injection and Catheter	1.55	1.41	2.08	**1.68**	Survey 25th percentile

Recommended Values and Relativity within the Family

- Injection Only Codes. The current survey recommended wRVU (25th percentile of survey) is generally consistent with the 2018 RUC recommended wRVU demonstrating that the Brachial Plexus injection (64415) is more work and higher wRVU than the other injection codes. In addition, the other three injection only codes (64417, 64445, 64447) have similar wRVUs in both the 2018 RUC recommended wRVU and the current survey recommended wRVU.

- Additional work for catheter placement. The current survey recommended wRVU and the 2018 RUC recommended wRVU maintain relativity with the injection only codes. The current survey recommended values show an incremental increase in wRVU of 0.30-0.36 units and the 2018 RUC recommended values had an incremental increase in wRVU of 0.31-0.45 units. Further, the additional time for the catheter placement is 5-7 min in the current survey is consistent with the 2018 RUC survey that had additional time for catheter placement of 5-8 min.

CODE 64417

64417 Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed

Survey Description

ASA and ASIPP conducted a random survey of 4,393 members (4,093 ASA members and 300 ASIPP members). A total of 79 responses were received (78 ASA members and 1 ASIPP member). The median experience in the previous 12 months for all respondents was 10.

Recommendation – 64417

64417 – Recommendation Summary	
Work RVU	1.31 (survey 25th)
Physician Time	
Pre-Time	13/1/4
Intra-Time	10
Immediate Post Time	10
Total Time	38

Work RVU

The Survey median Work RVU was 1.60 and the survey 25th percentile was 1.31.

- We recommend the 25th percentile of 1.31.

This recommendation is less than current combined Work RVU of 64417 and 76942 which is 1.94 (1.27 + 0.67 = 1.94 Work RVUs).
Physician Time

Pre-Service Package: 1 (1 minute deducted from scrub, dress and wait)

Evaluation: 13 minutes

Positioning: 1

SDW: 4

Intra-Service Time: 10 minutes

Immediate Post Service: 10 minutes

Total Time: 38 minutes

Framework for Considering Time and Intensity When Imaging Is Bundled

In selecting the 25th percentile, the societies considered how time and intensity should be considered. They noted that it was important to compare the recommendation to not just the current injection code alone but compare it to the combined injection and imaging code.

Time

The societies noted that for 64417 intra-time stayed the same. They discussed that in general when surveying this code with imaging now bundled they would not expect the intra-time to increase significantly because for the majority of the intra-time the imaging and the injection physician work is occurring simultaneously.

Breakdown of Physician Work for Code 64417	
	Intra-service Time

Type of Physician Work	
Ultrasound Imaging	⟷
Injection	⟷

Intensity

Similar to thinking about time, the societies considered that intensity of the new surveyed code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the new code describes the physician work of doing both the injection and imaging simultaneously where in the older code only describes the physician work of doing only the injection alone.In reviewing the intensities, the societies concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

Source	CPT	IWPUT	Work RVU	Total Time	Pre-Time Evaluation	Pre-Time Positioning	Pre-Time SDW	Intra	Post
Current	64417	0.070	1.27	49	13	1	4	10	10
Current	76942	0.027	0.67	27	7	0	0	15	5
Current – Combined*	64417 + 76942	0.105	1.94	41	13	1	4	13	10
Recommendation	64417	0.074	1.31	38	13	1	4	10	10

*Combined intra time reflects efficiencies between CPT 64417 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64417 and 76942.

Key Reference Service (KRS) Code Comparison

The societies then compared the surveyed code to the top KRS codes and found that they provided further support that the recommendation was appropriate.

KRS1: The most typical KRS selected was CPT code 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed*)) with 36.71% respondents selecting this code. 96% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

KRS2: The second most typical KRS selected was CPT code 62323 (*Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)*) with 22.78% of the respondents selecting this code. 89% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed	1.27	0.078	35	15	10	10
64417	**Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed**	**1.31**	**0.074**	**38**	**18**	**10**	**10**
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	1.80	0.080	45	20	15	10

MPC Codes

Our recommended Work RVU of 1.31 is well bracketed by MPC codes with the similar intra-service time and similar total times and clinically similar and with similar intensities. The two MPC codes are code 20611 with a Work RVU of 1.10 and code 64483 with a Work RVU of 1.90.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	1.10	0.0791	27	12	10	5
64417	**Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed**	**1.31**	**0.074**	**38**	**18**	**10**	**10**
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	1.90	0.0816	49	24	15	10

Other Code Comparison

Societies also reviewed how the recommendation fit in with other codes with similar intra-service time, similar total time, clinically similar and with similar intensities and concluded that this provided further evidence of the appropriateness of the recommendation.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	1.27	0.0782	35	15	10	10
64417	**Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed**	**1.31**	**0.074**	**38**	**18**	**10**	**10**
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	1.70	0.0733	45	20	15	10

Summary

The societies recommend for code 64417 (*Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed*) the following:

Work RVU: 1.31 (25th percentile)

Physician Time

- Pre-Time: 13/1/4 minutes
- Intra-Service Time: 10 minutes
- Post Time: 10 minutes
- Total Time: 38 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64417

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNAs How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 47295
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization.

Specialty Anesthesiology Frequency 35566 Percentage 75.20 %

Specialty CRNAs Frequency 7095 Percentage 15.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 15,765 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Anesthesiology Frequency 11855 Percentage 75.19 %

Specialty CRNAs Frequency 2365 Percentage 15.00 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64417

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64445 Tracking Number Original Specialty Recommended RVU: **1.39**
Presented Recommended RVU: **1.39**
Global Period: 000 Current Work RVU: **1.00** RUC Recommended RVU: **1.39**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old female will undergo surgery for a right trimalleolar fracture open reduction and fixation and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A sciatic nerve block with ultrasound guidance is performed to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The anesthesiologist obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The anesthesiologist communicates with surgeon to confirm that a block is indicated for postoperative pain management, confirms that the surgical consent is complete and the surgeon has seen the patient, and confirms that the surgical site is marked per institutional protocol. The anesthesiologist inspects and prepares the ultrasound equipment, including appropriate transducers, needle guides if applicable, and probe covers, as well as the proper settings for the ultrasound equipment. The anesthesiologist obtains informed consent. The site of the proposed procedure is marked. The patient is monitored in a procedure room or operating room. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the sciatic nerve are identified and with ultrasound imaging, the nerve(s) are visualized, and the skin entry point is identified. A local anesthetic skin wheal is created. Under ultrasound guidance, a needle is advanced towards the sciatic nerve and correct position is confirmed. Under continuous ultrasound imaging, a local anesthetic solution with or without adjuvants is injected into the fascial compartment containing the sciatic nerve using intermittent aspiration and injection. The needle is removed. After cleaning of site, and occlusive dressing is placed.

Description of Post-Service Work: Observe the patient for any signs or symptoms of local anesthetic systemic toxicity. After several minutes have passed, evaluate the initial effects of the sciatic nerve block by physical examination to determine if the patient is developing appropriate weakness, numbness, and relief of pain in the expected nerve distribution. A procedure note is entered into the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021		
Presenter(s):	ASA: Richard Rosenquist, MD; Neal Cohen, MD; Gordon Morewood, MD ASIPP: Michael Lubrano, MD		
Specialty Society(ies):	ASA, ASIPP		
CPT Code:	64445		
Sample Size:	4867	**Resp N:**	76
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	12.00	**26.00**	63.00	400.00
Survey RVW:	0.50	1.39	**1.60**	1.83	2.88
Pre-Service Evaluation Time:			**12.00**		
Pre-Service Positioning Time:			**4.50**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	2.00	5.00	**10.00**	13.00	60.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64445	**Recommended Physician Work RVU: 1.39**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**1.00**	**1.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**18.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20611	000	1.10	**RUC Time**	1,069,935

CPT Descriptor 1 Arthrocentresis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,044,547

CPT Descriptor 2 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transverus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 28 **% of respondents:** 36.8 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 17.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 64445	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: 62323
Median Pre-Service Time	9.00	15.00	20.00
Median Intra-Service Time	10.00	10.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**24.00**	**35.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	53%	39%	4%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	56%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	56%	44%
Physical effort required	0%	81%	19%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	41%	52%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	69%	23%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	23%	62%	15%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	69%	31%
Physical effort required	8%	69%	23%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	77%	15%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Last surveyed at the October 2018 RUC meeting, the current codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 describe only injection of an anesthetic agent in the area of the peripheral nerve and/or catheter placement for postoperative pain management after surgery AND do not include imaging guidance. The imaging guidance was reported using 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*). In October 2018 the RUC identified that over 50% of the time codes 64415-64417 and 64446-64448 were reported with ultrasound imaging code

over 76942 The RUC referred these codes to the CPT Editorial Panel indicating they need to be bundled with imaging guidance. Although 644445 was not part of the original application, in reviewing billed together data as part of its work for submitting the CPT application, the American Society of Anesthesiologists (ASA) found that the 2021 RUC database indicated that 64445 is billed with code 76942 65.4% of the time. As a result, ASA included 64445 in its CPT application submission.

Therefore, the surveyed codes are new codes that describe both work of the injection with or without a catheter placement AND imaging guidance.

When imaging is provided, ultrasound described by code 76942 is the dominant imaging modality for all of codes.

Code	Percent CPT Code Billed with 76942 (2019)
64415	86.8%
64416	88.1%
64417	78.5%
64445	68.8%
64446	83.3%
64447	87.3%
64448	87.0%

Source: 2021 RUC Database

At their May 2021 meeting, the CPT Editorial Panel approved new descriptors for codes 64415-54417 and 6445-64448 where managing was bundled. ASA and the American Society of Interventional Pain Physicians (ASIPP) surveyed these codes for the October 2021 RUC meeting.

Summary of Recommendations for Codes 64415-64417 and 64445-64448

Code#	Description	Oct 2018 RUC Recommended Work Value Injection Code Only	Current (CMS) Work RVU Injection Code Only	Current Work RVU Injection Combined with Imaging (76942)	October 2021 Recommendation of New Codes with Imaging bundled	October 2021 Recommendation Rationale
64415	Brachial Plexus Injection only	1.42	1.35	2.02	**1.50**	Survey 25th percentile
64416	Brachial Plexus Injection and Catheter	1.81	1.48	2.15	**1.80**	Survey 25th percentile
64417	Axillary Nerve Injection only	1.27	1.27	1.94	**1.31**	Survey 25th percentile
64445	Sciatic Nerve Injection only	1.18	1.00	1.67	**1.39**	Survey 25th percentile
64446	Sciatic Nerve Injection and Catheter	1.54	1.36	2.03	**1.75**	Survey 25th percentile
64447	Femoral Nerve Injection only	1.10	1.10	1.77	**1.34**	Survey 25th percentile
64448	Femoral Nerve Injection and Catheter	1.55	1.41	2.08	**1.68**	Survey 25th percentile

Recommended Values and Relativity within the Family

- Injection Only Codes. The current survey recommended wRVU (25th percentile of survey) is generally consistent with the 2018 RUC recommended wRVU demonstrating that the Brachial Plexus injection (64415) is more work and higher wRVU than the other injection codes. In addition, the other three injection only codes (64417, 64445, 64447) have similar wRVUs in both the 2018 RUC recommended wRVU and the current survey recommended wRVU.

- Additional work for catheter placement. The current survey recommended wRVU and the 2018 RUC recommended wRVU maintain relativity with the injection only codes. The current survey recommended values show an incremental increase in wRVU of 0.30-0.36 units and the 2018 RUC recommended values had an incremental increase in wRVU of 0.31-0.45 units. Further, the additional time for the catheter placement is 5-7 min in the current survey is consistent with the 2018 RUC survey that had additional time for catheter placement of 5-8 min.

CODE 64445

64445 Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed

Survey Description

ASA and ASIPP conducted a random survey of 4,867 members (4,567 ASA members and 300 ASIPP members). A total of 76 responses were received (73 ASA members and 3 ASIPP member). The median experience in the previous 12 months for all respondents was 26.

Recommendation – 64445

64445 – Recommendation Summary	
Work RVU	1.39 (survey 25th)
Physician Time	
Pre-Time	7/1/1
Intra-Time	10
Immediate Post Time	5
Total Time	24

Work RVU

The Survey median Work RVU was 1.60 and the survey 25th percentile was 1.39.

- We recommend the 25th percentile of 1.39.

This recommendation is less than current combined Work RVU of 64445 and 76942 which is 1.67 (1.00 + 0.67 = 1.67 Work RVUs).

Physician Time

Pre-Service Package: 5

Evaluation: 7 minutes

Positioning: 1

SDW: 1

Intra-Service Time: 10 minutes

Immediate Post Service: 5 minutes

Total Time: 24 minutes

Framework for Considering Time and Intensity When Imaging Is Bundled

In selecting the 25th percentile, the societies considered how time and intensity should be considered. They noted that it was important to compare the recommendation to not just the current injection code alone but compare it to the combined injection and imaging code.

Time

The societies noted that for 64445 intra-time stayed the same. They discussed that in general when surveying this code with imaging now bundled they would not expect the intra-time to increase significantly because for the majority of the intra-time the imaging and the injection physician work is occurring simultaneously.

Breakdown of Physician Work for Code 64445	
	Intra-service Time

Type of Physician Work	
Ultrasound Imaging	⟷
Injection	⟷

Intensity

Similar to thinking about time, the societies considered that intensity of the new surveyed code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the new code describes the physician work of doing both the injection and imaging simultaneously where in the older code only describes the physician work of doing only the injection alone. In reviewing the intensities, the societies concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

Source	CPT	IWPUT	Work RVU	Total Time	Pre-Time Evaluation	Pre-Time Positioning	Pre-Time SDW	Intra	Post
Current	64445	0.0701	1.00	24	7	1	1	10	5
Current	76942	0.027	0.67	27	7	0	0	15	5
Current – Combined*	64445 + 76942	0.105	1.67	27	7	1	1	13	5
Recommendation	64445	0.109	1.39	24	7	1	1	10	5

*Combined intra time reflects efficiencies between CPT 64445 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64445 and 76942.

Key Reference Service (KRS) Code Comparison

The societies then compared the surveyed code to the top KRS codes and found that they provided further support that the recommendation was appropriate.

KRS1: The most typical KRS selected was CPT code 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed*)) with 36.84% respondents selecting this code. 96% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

KRS2: The second most typical KRS selected was CPT code 62323 (*Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)*) with 17.11% of the respondents selecting this code. 92% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed	1.27	0.078	35	15	10	10
64445	**Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed**	**1.39**	**0.109**	**24**	**9**	**10**	**5**
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	1.80	0.080	45	20	15	10

MPC Codes

Our recommended Work RVU of 1.39 is well bracketed by MPC codes with the similar intra-service time and similar total times and clinically similar and with similar intensities. The two MPC codes are code 20611 with a Work RVU of 1.10 and code 64483 with a Work RVU of 1.90.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	1.10	0.0791	27	12	10	5
64445	**Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed**	**1.39**	**0.109**	**24**	**9**	**10**	**5**
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	1.90	0.0816	49	24	15	10

Other Code Comparison

Societies also reviewed how the recommendation fit in with other codes with similar intra-service time, similar total time, clinically similar and with similar intensities and concluded that this provided further evidence of the appropriateness of the recommendation.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	1.27	0.0782	35	15	10	10
64445	**Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed**	**1.39**	**0.109**	**24**	**9**	**10**	**5**
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	1.70	0.0733	45	20	15	10

Summary

The societies recommend for code 64445 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed)* the following:

Work RVU: 1.39 (25th percentile)

Physician Time

- Pre-Time: 7/1/1 minutes
- Intra-Service Time: 10 minutes
- Post Time: 5 minutes
- Total Time: 24 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64445

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Family Medicine How often? Rarely

Specialty Physical Medicine and Rehab How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 392157
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization.

Specialty Anesthesiology Frequency 145490 Percentage 37.09 %

Specialty Family Medicine Frequency 84314 Percentage 21.50 %

Specialty Physical Medicine & Rehab Frequency 26274 Percentage 6.69 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 130,719 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Anesthesiology Frequency 48497 Percentage 37.10 %

Specialty Family Medicine Frequency 28105 Percentage 21.50 %

Specialty Physical Medicine & Rehab Frequency 8758 Percentage 6.69 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64445

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64446 Tracking Number Original Specialty Recommended RVU: **1.75**
Presented Recommended RVU: **1.75**
Global Period: 000 Current Work RVU: **1.36** RUC Recommended RVU: **1.75**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male will undergo surgery for major reconstruction of his left foot and ankle and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A continuous sciatic nerve block with a catheter and a continuous infusion of local anesthetic with ultrasound guidance is performed to relieve his pain and improve his function.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The anesthesiologist obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The anesthesiologist communicates with surgeon to confirm that a block is indicated for postoperative pain management, confirms that the surgical consent is complete and the surgeon has seen the patient, and confirms that the surgical site is marked per institutional protocol. The anesthesiologist inspects and prepares the ultrasound equipment, including appropriate transducers, needle guides if applicable, and probe covers, as well as the proper settings for the ultrasound equipment. The anesthesiologist obtains informed consent. The site of the proposed procedure is marked. The patient is monitored in a procedure room or operating room. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the sciatic nerve are identified and with ultrasound imaging, the nerve(s) are visualized, and the skin entry point is identified. A local anesthetic skin wheal is created. Under ultrasound guidance, a needle is advanced towards the sciatic nerve and correct position is confirmed. Under continuous ultrasound imaging, a local anesthetic or crystalloid solution is injected into the fascial compartment containing the sciatic nerve using intermittent aspiration and injection. A catheter is advanced carefully under ultrasound guidance to lie next to the sciatic nerve then the needle is removed. Local anesthetic is injected via the catheter. The catheter is secured and an occlusive dressing is placed.

Description of Post-Service Work: Observe the patient for any signs or symptoms of local anesthetic systemic toxicity. After several minutes have passed, evaluate the initial effects of the sciatic nerve block by physical examination to determine if the patient is developing appropriate weakness, numbness, and relief of pain in the expected nerve distribution. A procedure note is entered into the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	ASA: Richard Rosenquist, MD; Neal Cohen, MD; Gordon Morewood, MD ASIPP: Michael Lubrano, MD					
Specialty Society(ies):	ASA, ASIPP					
CPT Code:	64446					
Sample Size:	4867	**Resp N:**	60			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**10.00**	21.00	300.00	
Survey RVW:	1.20	1.75	**1.90**	2.03	3.50	
Pre-Service Evaluation Time:			**16.50**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**5.00**			
Intra-Service Time:	2.00	11.00	**15.00**	19.00	120.00	
Immediate Post Service-Time:	**9.50**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	_____	99291x	99292x			
Other Hospital time/visit(s):	_____	99231x	99232x	99233x		
Discharge Day Mgmt:	_____	99238x	99239x	99217x		
Office time/visit(s):	_____	99211x	12x	13x	14x	15x
Prolonged Services:	_____	99354x	55x	56x	57x	
Sub Obs Care:	_____	99224x	99225x	99226x		

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64446	**Recommended Physician Work RVU: 1.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62327	000	1.90	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62325	000	2.20	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20611	000	1.10	**RUC Time**	1,069,935

CPT Descriptor 1 Arthrocentresis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reportin

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64833	000	1.90	**RUC Time**	1,044,547

CPT Descriptor 2 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
64479	000	2.29	**RUC Time**

CPT Descriptor Injection(s), anesthetic agent(s) and/or steriod; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 **% of respondents:** 48.3 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 18.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 64446	Top Key Reference CPT Code: 62327	2nd Key Reference CPT Code: **62325**
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	15.00	15.00	15.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**44.00**	**45.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	52%	28%	3%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	36%	54%	11%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	61%	29%
Physical effort required	4%	68%	29%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	21%	61%	18%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	9%	82%	9%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	73%	18%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	9%	64%	27%
Physical effort required	9%	64%	27%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	18%	45%	36%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Last surveyed at the October 2018 RUC meeting, the current codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 describe only injection of an anesthetic agent in the area of the peripheral nerve and/or catheter placement for postoperative pain management after surgery AND do not include imaging guidance. The imaging guidance was reported using 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*). In October 2018 the RUC identified that over 50% of the time codes 64415-64417 and 64446-64448 were reported with ultrasound imaging code over 76942 The RUC referred these codes to the CPT Editorial Panel indicating they need to be bundled with imaging guidance. Although 644445 was not part of the original application, in reviewing billed together data as part of its work for submitting the CPT application, the American Society of Anesthesiologists (ASA) found that the 2021 RUC database indicated that 64445 is billed with code 76942 65.4% of the time. As a result ASA included 64445 in its CPT application submission.

Therefore, the surveyed codes are new codes that describe both work of the injection with or without a catheter placement AND imaging guidance.

When imaging is provided, ultrasound described by code 76942 is the dominant imaging modality for all of codes.

Code	Percent CPT Code Billed with 76942 (2019)
64415	86.8%
64416	88.1%
64417	78.5%
64445	68.8%
64446	83.3%
64447	87.3%
64448	87.0%

Source: 2021 RUC Database

At their May 2021 meeting, the CPT Editorial Panel approved new descriptors for codes 64415-54417 and 6445-64448 where managing was bundled. ASA and the American Society of Interventional Pain Physicians (ASIPP) surveyed these codes for the October 2021 RUC meeting.

Summary of Recommendations for Codes 64415-64417 and 64445-64448

Code#	Description	Oct 2018 RUC Recommended Work Value Injection Code Only	Current (CMS) Work RVU Injection Code Only	Current Work RVU Injection Combined with Imaging (76942)	October 2021 Recommendation of New Codes with Imaging bundled	October 2021 Recommendation Rationale
64415	Brachial Plexus Injection only	1.42	1.35	2.02	**1.50**	Survey 25th percentile
64416	Brachial Plexus Injection and Catheter	1.81	1.48	2.15	**1.80**	Survey 25th percentile
64417	Axillary Nerve Injection only	1.27	1.27	1.94	**1.31**	Survey 25th percentile
64445	Sciatic Nerve Injection only	1.18	1.00	1.67	**1.39**	Survey 25th percentile
64446	Sciatic Nerve Injection and Catheter	1.54	1.36	2.03	**1.75**	Survey 25th percentile
64447	Femoral Nerve Injection only	1.10	1.10	1.77	**1.34**	Survey 25th percentile
64448	Femoral Nerve Injection and Catheter	1.55	1.41	2.08	**1.68**	Survey 25th percentile

Recommended Values and Relativity within the Family

- Injection Only Codes. The current survey recommended wRVU (25th percentile of survey) is generally consistent with the 2018 RUC recommended wRVU demonstrating that the Brachial Plexus injection (64415) is more work and higher wRVU than the other injection codes. In addition, the other three injection only codes (64417, 64445, 64447) have similar wRVUs in both the 2018 RUC recommended wRVU and the current survey recommended wRVU.
- Additional work for catheter placement. The current survey recommended wRVU and the 2018 RUC recommended wRVU maintain relativity with the injection only codes. The current survey recommended values show an incremental increase in wRVU of 0.30-0.36 units and the 2018 RUC recommended values had an incremental increase in wRVU of 0.31-0.45 units. Further, the additional time for the catheter placement is 5-7 min in the current survey is consistent with the 2018 RUC survey that had additional time for catheter placement of 5-8 min.

CODE 64446

64446 Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed

Survey Description

ASA and ASIPP conducted a random survey of 4,867 members (4,567 ASA members and 300 ASIPP members). A total of 60 responses were received (57 ASA members and 3 ASIPP member). The median experience in the previous 12 months for all respondents was 10.

Recommendation – 64446

64446 – Recommendation Summary	
Work RVU	1.75 (survey 25th)
Physician Time	
Pre-Time	13/1/5
Intra-Time	15
Immediate Post Time	10
Total Time	44

Work RVU

The Survey median Work RVU was 1.90 and the survey 25th percentile was 1.75.

- We recommend the 25th percentile of 1.75.

This recommendation is less than current combined Work RVU of 64446 and 76942 which is 2.03 (1.36 + 0.67 = 2.03 Work RVUs).

Physician Time

Pre-Service Package: 1 (1 minute from scrub, dress and wait)

Evaluation: 13 minutes

Positioning: 1

SDW: 5

Intra-Service Time: 15 minutes

Immediate Post Service: 10 minutes

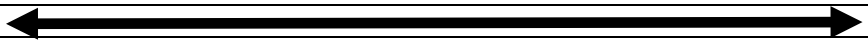
Total Time: 44 minutes

Framework for Considering Time and Intensity When Imaging Is Bundled

In selecting the 25th percentile, the societies considered how time and intensity should be considered. They noted that it was important to compare the recommendation to not just the current injection code alone but compare it to the combined injection and imaging code.

Time

The societies noted that for 64446 intra-time stayed the same. They discussed that in general when surveying this code with imaging now bundled they would not expect the intra-time to increase significantly because for the majority of the intra-time the imaging and the injection physician work is occurring simultaneously.

Breakdown of Physician Work for Code 64446	
	Intra-service Time
Type of Physician Work	
Ultrasound Imaging	
Catheter Placement and Injection	

Intensity

Similar to thinking about time, the societies considered that intensity of the new surveyed code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the new code describes the physician work of doing both the injection and imaging simultaneously where in the older code only describes the physician work of doing only the injection alone. In reviewing the intensities, the societies concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

Source	**CPT**	**IWPUT**	**Work RVU**	**Total Time**	**Pre-Time Evaluation**	**Pre-Time Positioning**	**Pre-Time SDW**	**Intra**	**Post**
Current	64446	0.0581	1.36	40	13	1	5	15	6
Current	76942	0.027	0.67	27	7	0	0	15	5
Current – Combined*	64446 + 76942	0.086	2.03	43	13	1	5	18	6
Recommendation	64446	0.078	1.75	44	13	1	5	15	10

*Combined intra time reflects efficiencies between CPT 64446 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64446 and 76942.

Key Reference Service (KRS) Code Comparison

The societies then compared the surveyed code to the top KRS codes and found that they provided further support that the recommendation was appropriate.

KRS1: The most typical KRS selected was CPT code 62327 (*Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)*) with 48.33% of the respondents selecting this code. 83% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

KRS2: The most typical KRS selected was CPT code 62325 (*Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT*)) with 18.33% respondents selecting this code. With 91% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

CPT	**DESCRIPTOR**	**RVW**	**IWPUT**	**TOTAL TIME**	**PRE**	**INTRA**	**POST**
64446	**Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed**	**1.75**	**0.078**	**44**	**19**	**15**	**10**
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances,	1.90	0.0866	45	20	15	10

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
	interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)						
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	2.20	0.1066	45	20	15	10

MPC Codes

Our recommended Work RVU of 1.75 is well bracketed by MPC codes with the similar intra-service time and similar total times and clinically similar and with similar intensities. The two MPC codes are code 20611 with a Work RVU of 1.10 and code 64483 with a Work RVU of 1.90.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	1.10	0.0791	27	12	10	5
64446	**Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed**	**1.75**	**0.078**	**44**	**19**	**15**	**10**
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	1.90	0.0816	49	24	15	10

Other Comparison Codes

Societies also reviewed how the recommendation fit in with other codes with similar intra-service time, similar total time, clinically similar and with similar intensities and concluded that this provided further evidence of the appropriateness of the recommendation.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64488	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)	1.60	0.0741	40	15	15	10
64446	**Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed**	**1.75**	**0.078**	**44**	**19**	**15**	**10**
64479	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, single level	2.29	0.1076	49	24	15	10

Summary

The societies recommend for code 64446 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed)* the following:

Work RVU: 1.75 (25th percentile)

Physician Time

- Pre-Time: 13/1/5 minutes

- Intra-Service Time: 15 minutes
- Post Time: 10 minutes
- Total Time: 44 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64446

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNAs How often? Rarely

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 17640
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization.

Specialty Anesthesiology Frequency 16194 Percentage 91.80 %

Specialty CRNAs Frequency 811 Percentage 4.59 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,880
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Anesthesiology Frequency 5398 Percentage 91.80 %

Specialty CRNAs Frequency 270 Percentage 4.59 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64446

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64447 Tracking Number Original Specialty Recommended RVU: **1.34**
Presented Recommended RVU: **1.34**
Global Period: 000 Current Work RVU: **1.10** RUC Recommended RVU: **1.34**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male will undergo surgery for a right anterior cruciate ligament repair and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A femoral nerve block with ultrasound guidance is performed to manage post-operative pain and improve his function.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: the medical record and any pertinent imaging studies, laboratory studies and medical information. The anesthesiologist communicates with surgeon to confirm that a block is indicated for postoperative pain management, confirms that the surgical consent is complete and the surgeon has seen the patient, and confirms that the surgical site is marked per institutional protocol.The anesthesiologist inspects and prepares the ultrasound equipment, including appropriate transducers, needle guides if applicable, and probe covers, as well as the proper settings for the ultrasound equipment. The anesthesiologist obtains informed consent. The site of the proposed procedure is marked. The patient is monitored in a procedure room or operating room. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the femoral nerve are identified and with ultrasound imaging,the nerve(s) are visualized, and the skin entry point is identified. A local anesthetic skin wheal is created. Under ultrasound guidance, a needle is advanced towards the femoral nerve and correct position is confirmed. Under continuous ultrasound imaging, a local anesthetic solution with or without adjuvants is injected into the fascial compartment containing the femoral nerve using intermittent aspiration and injection. The needle is removed. After cleaning of site, and occlusive dressing is placed.

Description of Post-Service Work: Observe the patient for any signs or symptoms of local anesthetic systemic toxicity. After several minutes have passed, evaluate the initial effects of the femoral nerve block by physical examination to determine if the patient is developing appropriate weakness, numbness, and relief of pain in the expected nerve distribution. A procedure note is entered into the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	ASA: Richard Rosenquist, MD; Neal Cohen, MD; Gordon Morewood, MD ASIPP: Michael Lubrano, MD					
Specialty Society(ies):	ASA, ASIPP					
CPT Code:	64447					
Sample Size:	4867	**Resp N:**	76			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	12.00	**30.00**	71.00	300.00	
Survey RVW:	0.95	1.34	**1.51**	1.80	2.83	
Pre-Service Evaluation Time:			**12.50**			
Pre-Service Positioning Time:			**3.00**			
Pre-Service Scrub, Dress, Wait Time:			**3.00**			
Intra-Service Time:	2.00	5.00	**8.00**	10.00	60.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64447	**Recommended Physician Work RVU: 1.34**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**12.00**	**13.00**	**-1.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**3.00**	**6.00**	**-3.00**
Intra-Service Time:		**8.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**18.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64493	000	1.52	**RUC Time**

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20611	000	1.10	**RUC Time**	1,069,935

CPT Descriptor 1 Arthrocentresis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64833	000	1.90	**RUC Time**	1,044,547

CPT Descriptor 2 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 32 **% of respondents:** 42.1 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 15.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 64447	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: **64493**
Median Pre-Service Time	16.00	15.00	17.00
Median Intra-Service Time	8.00	10.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**29.00**	**35.00**	**42.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	3%	60%	34%	3%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	61%	32%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	68%	32%
Physical effort required	3%	87%	10%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	48%	45%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	67%	25%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	50%	42%	8%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	67%	25%
Physical effort required	17%	66%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	67%	8%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Last surveyed at the October 2018 RUC meeting, the current codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 describe only injection of an anesthetic agent in the area of the peripheral nerve and/or catheter placement for postoperative pain management after surgery AND do not include imaging guidance. The imaging guidance was reported using 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*). In October 2018 the RUC identified that over 50% of the time codes 64415-64417 and 64446-64448 were reported with ultrasound imaging code

over 76942 The RUC referred these codes to the CPT Editorial Panel indicating they need to be bundled with imaging guidance. Although 644445 was not part of the original application, in reviewing billed together data as part of its work for submitting the CPT application, the American Society of Anesthesiologists (ASA) found that the 2021 RUC database indicated that 64445 is billed with code 76942 65.4% of the time. As a result ASA included 64445 in its CPT application submission.

Therefore, the surveyed codes are new codes that describe both work of the injection with or without a catheter placement AND imaging guidance.

When imaging is provided, ultrasound described by code 76942 is the dominant imaging modality for all of codes.

Code	Percent CPT Code Billed with 76942 (2019)
64415	86.8%
64416	88.1%
64417	78.5%
64445	68.8%
64446	83.3%
64447	87.3%
64448	87.0%

Source: 2021 RUC Database

At their May 2021 meeting, the CPT Editorial Panel approved new descriptors for codes 64415-54417 and 6445-64448 where managing was bundled. ASA and the American Society of Interventional Pain Physicians (ASIPP) surveyed these codes for the October 2021 RUC meeting.

Summary of Recommendations for Codes 64415-64417 and 64445-64448

Code #	Description	Oct 2018 RUC Recommended Work Value Injection Code Only	Current (CMS) Work RVU Injection Code Only	Current Work RVU Injection Combined with Imaging (76942)	October 2021 Recommendation of New Codes with Imaging bundled	October 2021 Recommendation Rationale
64415	Brachial Plexus Injection only	1.42	1.35	2.02	**1.50**	Survey 25th percentile
64416	Brachial Plexus Injection and Catheter	1.81	1.48	2.15	**1.80**	Survey 25th percentile
64417	Axillary Nerve Injection only	1.27	1.27	1.94	**1.31**	Survey 25th percentile
64445	Sciatic Nerve Injection only	1.18	1.00	1.67	**1.39**	Survey 25th percentile
64446	Sciatic Nerve Injection and Catheter	1.54	1.36	2.03	**1.75**	Survey 25th percentile
64447	Femoral Nerve Injection only	1.10	1.10	1.77	**1.34**	Survey 25th percentile
64448	Femoral Nerve Injection and Catheter	1.55	1.41	2.08	**1.68**	Survey 25th percentile

Recommended Values and Relativity within the Family

- Injection Only Codes. The current survey recommended wRVU (25th percentile of survey) is generally consistent with the 2018 RUC recommended wRVU demonstrating that the Brachial Plexus injection (64415) is more work and higher wRVU than the other injection codes. In addition, the other three injection only codes (64417, 64445, 64447) have similar wRVUs in both the 2018 RUC recommended wRVU and the current survey recommended wRVU.
- Additional work for catheter placement. The current survey recommended wRVU and the 2018 RUC recommended wRVU maintain relativity with the injection only codes. The current survey recommended values show an incremental increase in wRVU of 0.30-0.36 units and the 2018 RUC recommended values had an incremental increase in wRVU of 0.31-0.45

units. Further, the additional time for the catheter placement is 5-7 min in the current survey is consistent with the 2018 RUC survey that had additional time for catheter placement of 5-8 min.

CODE 64447

64447 Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed

Survey Description

ASA and ASIPP conducted a random survey of 4,867 members (4,567 ASA members and 300 ASIPP members). A total of 76 responses were received (73 ASA members and 3 ASIPP member). The median experience in the previous 12 months for all respondents was 30.

Recommendation – 64447

64447 – Recommendation Summary	
Work RVU	1.34 (survey 25th)
Physician Time	
Pre-Time	12/1/3
Intra-Time	8
Immediate Post Time	5
Total Time	29

Work RVU

The Survey median Work RVU was 1.51 and the survey 25th percentile was 1.34.

- We recommend the 25th percentile of 1.34.

This recommendation is less than current combined Work RVU of 64447 and 76942 which is 1.77 (1.10 + 0.67 = 1.77) Work RVUs).

Physician Time

Pre-Service Package: 1 (1 minute deducted from evaluation, 3 minutes deducted from scrub, dress and wait)

Evaluation: 12 minutes

Positioning: 1

SDW: 3

Intra-Service Time: 8 minutes

Immediate Post Service: 5 minutes

Total Time: 29 minutes

Framework for Considering Time and Intensity When Imaging Is Bundled

In selecting the 25th percentile, the societies considered how time and intensity should be considered. They noted that it was important to compare the recommendation to not just the current injection code alone but compare it to the combined injection and imaging code.

Time

The societies noted that for 64447 intra-time increased by 2 minutes. They discussed that in general when surveying this code with imaging now bundled they would not expect the intra-time to increase significantly because for the majority of the intra-time the imaging and the injection physician work is occurring simultaneously.

Breakdown of Physician Work for Code 64447	
	Intra-service Time

Type of Physician Work	
Ultrasound Imaging	← →
Injection	← →

Intensity

Similar to thinking about time, the societies considered that intensity of the new surveyed code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the new code describes the physician work of doing both the injection and imaging simultaneously where in the older code only describes the physician work of doing only the injection alone. In reviewing the intensities, the societies concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

Source	CPT	IWPUT	Work RVU	Total Time	Pre-Time Evaluation	Pre-Time Positioning	Pre-Time SDW	Intra	Post
Current	64447	0.112	1.10	27	12	1	3	6	5
Current	76942	0.027	0.67	27	7	0	0	15	5
Current – Combined*	64447 + 76942	0.149	1.77	30	12	1	3	9	5
Recommendation	64447	0.114	1.34	29	12	1	3	8	5

*Combined intra time reflects efficiencies between CPT 64447 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64447 and 76942.

Key Reference Service (KRS) Code Comparison

The societies then compared the surveyed code to the top KRS codes and found that they provided further support that the recommendation was appropriate.

KRS1: The most typical KRS selected was CPT code 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed*)) with 42.11% respondents selecting this code. 97% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

KRS2: The second most typical KRS selected was CPT code 64493 (*Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level*) with 15.79% of the respondents selecting this code. 92% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed	1.27	0.078	35	15	10	10
64447	**Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed**	**1.34**	**0.114**	**29**	**16**	**8**	**5**
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	1.52	0.0658	42	17	15	10

MPC Codes

Our recommended Work RVU of 1.34 is well bracketed by MPC codes with the similar intra-service time and similar total times and clinically similar and with similar intensities. The two MPC codes are code 20611 with a Work RVU of 1.10 and code 64483 with a Work RVU of 1.90.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	1.10	0.0791	27	12	10	5
64447	**Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed**	**1.34**	**0.114**	**29**	**16**	**8**	**5**
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	1.90	0.0816	49	24	15	10

Other Comparison Codes

Societies also reviewed how the recommendation fit in with other codes with similar intra-service time, similar total time, clinically similar and with similar intensities and concluded that this provided further evidence of the appropriateness of the recommendation.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	1.27	0.0782	35	15	10	10
64447	**Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed**	**1.34**	**0.114**	**29**	**16**	**8**	**5**
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	1.70	0.0733	45	20	15	10

Summary

The societies recommend for code 64447 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed)* the following:

Work RVU: 1.34 (25th percentile)

Physician Time

- Pre-Time: 12/1/3 minutes
- Intra-Service Time: 8 minutes
- Post Time: 5 minutes
- Total Time: 29 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64447

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNAs How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 848109
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization.

Specialty Anesthesiology Frequency 643715 Percentage 75.90 %

Specialty CRNAs Frequency 79723 Percentage 9.40 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 282,703 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Anesthesiology Frequency 214572 Percentage 75.90 %

Specialty CRNAs Frequency 26575 Percentage 9.40 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:

Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64447

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64448 Tracking Number Original Specialty Recommended RVU: **1.68**
Presented Recommended RVU: **1.68**
Global Period: 000 Current Work RVU: **1.41** RUC Recommended RVU: **1.68**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male will undergo surgery for a right total knee replacement and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A continuous femoral nerve block with a catheter and a continuous infusion of local anesthetic with ultrasound guidance is performed to manage post-operative pain and improve his function.

Percentage of Survey Respondents who found Vignette to be Typical: 84%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The anesthesiologist obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The anesthesiologist communicates with surgeon to confirm that a block is indicated for postoperative pain management, confirms that the surgical consent is complete and the surgeon has seen the patient, and confirms that the surgical site is marked per institutional protocol. The anesthesiologist inspects and prepares the ultrasound equipment, including appropriate transducers, needle guides if applicable, and probe covers, as well as the proper settings for the ultrasound equipment.The anesthesiologist obtains informed consent. The site of the proposed procedure is marked. The patient is monitored in a procedure room or operating room. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the femoral nerve are identified and with ultrasound imaging, the nerve(s) are visualized, and the skin entry point is identified. A local anesthetic skin wheal is created. Under ultrasound guidance, a needle is advanced towards the femoral nerve and correct position is confirmed. Under continuous ultrasound imaging, a local anesthetic or crystalloid solution is injected into the fascial compartment containing the femoral nerve using intermittent aspiration and injection. A catheter is advanced carefully under ultrasound guidance to lie next to the femoral nerve then the needle is removed. Local anesthetic is injected via the catheter. The catheter is secured and an occlusive dressing is placed.

Description of Post-Service Work: Observe the patient for any signs or symptoms of local anesthetic systemic toxicity. After several minutes have passed, evaluate the initial effects of the femoral nerve block by physical examination to determine if the patient is developing appropriate weakness, numbness, and relief of pain in the expected nerve distribution. A procedure note is entered into the medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	ASA: Richard Rosenquist, MD; Neal Cohen, MD; Gordon Morewood ASIPP: Michael Lubrano					
Specialty Society(ies):	ASA, ASIPP					
CPT Code:	64448					
Sample Size:	4867	**Resp N:**	62			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**10.00**	20.00	300.00	
Survey RVW:	1.00	1.68	**1.90**	2.00	5.00	
Pre-Service Evaluation Time:			**16.00**			
Pre-Service Positioning Time:			**4.50**			
Pre-Service Scrub, Dress, Wait Time:			**5.00**			
Intra-Service Time:	2.00	10.00	**15.00**	17.00	120.00	
Immediate Post Service-Time:	**9.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64448	**Recommended Physician Work RVU: 1.68**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**9.00**	**18.00**	**-9.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62327	000	1.90	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62325	000	2.20	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20611	000	1.10	**RUC Time**	1,069,935

CPT Descriptor 1 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,044,547

CPT Descriptor 2 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
10035	000	1.70	**RUC Time**

CPT Descriptor Placement of soft tissue localization device(s) (eg. clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 29 **% of respondents:** 46.7 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 14.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 64448	Top Key Reference CPT Code: 62327	2nd Key Reference CPT Code: **62325**
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	15.00	15.00	15.00
Median Immediate Post-service Time	9.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**43.00**	**45.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	17%	52%	28%	3%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	32%	54%	14%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	53%	36%
Physical effort required	4%	71%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	57%	18%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	67%	22%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	78%	11%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	56%	33%
Physical effort required	11%	67%	22%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	22%	56%	22%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

Last surveyed at the October 2018 RUC meeting, the current codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 describe only injection of an anesthetic agent in the area of the peripheral nerve and/or catheter placement for postoperative pain management after surgery AND do not include imaging guidance. The imaging guidance was reported using 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*). In October 2018 the RUC identified that over 50% of the time codes 64415-64417 and 64446-64448 were reported with ultrasound imaging code over 76942 The RUC referred these codes to the CPT Editorial Panel indicating they need to be bundled with imaging guidance. Although 644445 was not part of the original application, in reviewing billed together data as part of its work for submitting the CPT application, the American Society of Anesthesiologists (ASA) found that the 2021 RUC database indicated that 64445 is billed with code 76942 65.4% of the time. As a result ASA included 64445 in its CPT application submission.

Therefore, the surveyed codes are new codes that describe both work of the injection with or without a catheter placement AND imaging guidance.

When imaging is provided, ultrasound described by code 76942 is the dominant imaging modality for all of codes.

Code	Percent CPT Code Billed with 76942 (2019)
64415	86.8%
64416	88.1%
64417	78.5%
64445	68.8%
64446	83.3%
64447	87.3%
64448	87.0%

Source: 2021 RUC Database

At their May 2021 meeting, the CPT Editorial Panel approved new descriptors for codes 64415-54417 and 6445-64448 where managing was bundled. ASA and the American Society of Interventional Pain Physicians (ASIPP) surveyed these codes for the October 2021 RUC meeting.

Summary of Recommendations for Codes 64415-64417 and 64445-64448

Code #	Description	Oct 2018 RUC Recommended Work Value Injection Code Only	Current (CMS) Work RVU Injection Code Only	Current Work RVU Injection Combined with Imaging (76942)	October 2021 Recommendation of New Codes with Imaging bundled	October 2021 Recommendation Rationale
64415	Brachial Plexus Injection only	1.42	1.35	2.02	**1.50**	Survey 25th percentile
64416	Brachial Plexus Injection and Catheter	1.81	1.48	2.15	**1.80**	Survey 25th percentile
64417	Axillary Nerve Injection only	1.27	1.27	1.94	**1.31**	Survey 25th percentile
64445	Sciatic Nerve Injection only	1.18	1.00	1.67	**1.39**	Survey 25th percentile
64446	Sciatic Nerve Injection and Catheter	1.54	1.36	2.03	**1.75**	Survey 25th percentile
64447	Femoral Nerve Injection only	1.10	1.10	1.77	**1.34**	Survey 25th percentile
64448	Femoral Nerve Injection and Catheter	1.55	1.41	2.08	**1.68**	Survey 25th percentile

Recommended Values and Relativity within the Family

- Injection Only Codes. The current survey recommended wRVU (25th percentile of survey) is generally consistent with the 2018 RUC recommended wRVU demonstrating that the Brachial Plexus injection (64415) is more work and higher wRVU

than the other injection codes. In addition, the other three injection only codes (64417, 64445, 64447) have similar wRVUs in both the 2018 RUC recommended wRVU and the current survey recommended wRVU.

- Additional work for catheter placement. The current survey recommended wRVU and the 2018 RUC recommended wRVU maintain relativity with the injection only codes. The current survey recommended values show an incremental increase in wRVU of 0.30-0.36 units and the 2018 RUC recommended values had an incremental increase in wRVU of 0.31-0.45 units. Further, the additional time for the catheter placement is 5-7 min in the current survey is consistent with the 2018 RUC survey that had additional time for catheter placement of 5-8 min.

CODE 64448

64448 Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed

Survey Description

ASA and ASIPP conducted a random survey of 4,867 members (4,567 ASA members and 300 ASIPP members). A total of 62 responses were received (59 ASA members and 3 ASIPP member). The median experience in the previous 12 months for all respondents was 10.

Recommendation – 64448

64448 – Recommendation Summary	
Work RVU	1.68 (survey 25th)
Physician Time	
Pre-Time	13/1/5
Intra-Time	15
Immediate Post Time	9
Total Time	43

Work RVU

The Survey median Work RVU was 1.90 and the survey 25th percentile was 1.68.

- We recommend the 25th percentile of 1.68.

This recommendation is less than current combined Work RVU of 64448 and 76942 which is 2.08 (1.41 + 0.67 = 2.08) Work RVUs).

Physician Time

Pre-Service Package: 1 (1 minute deducted from scrub, dress and wait)

Evaluation: 13 minutes

Positioning: 1

SDW: 5

Intra-Service Time: 15 minutes

Immediate Post Service: 9 minutes

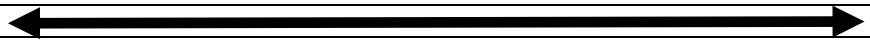
Total Time: 43 minutes

Framework for Considering Time and Intensity When Imaging Is Bundled

In selecting the 25th percentile, the societies considered how time and intensity should be considered. They noted that it was important to compare the recommendation to not just the current injection code alone but compare it to the combined injection and imaging code.

Time

The societies noted that for 64448 intra-time increased by 2 minutes. They discussed that in general when surveying this code with imaging now bundled they would not expect the intra-time to increase significantly because for the majority of the intra-time the imaging and the injection physician work is occurring simultaneously.

Breakdown of Physician Work for Code 64448	
	Intra-service Time
Type of Physician Work	
Ultrasound Imaging	
Catheter Placement and Injection	

Intensity

Similar to thinking about time, the societies considered that intensity of the new surveyed code should be compared to the intensity of the combined injection and imaging codes which appropriately have higher intensities. The higher intensities are appropriate because the new code describes the physician work of doing both the injection and imaging simultaneously where in the older code only describes the physician work of doing only the injection alone. In reviewing the intensities, the societies concluded that they provided further support of the appropriateness of the recommendation of the 25th percentile.

Source	CPT	IWPUT	Work RVU	Total Time	Pre-Time Evaluation	Pre-Time Positioning	Pre-Time SDW	Intra	Post
Current	64448	0.071	1.41	38	13	1	5	13	6
Current	76942	0.027	0.67	27	7	0	0	15	5
Current – Combined*	64448 + 76942	0.099	2.08	41	13	1	5	16	6
Recommendation	64448	0.075	1.68	43	13	1	5	15	9

*Combined intra time reflects efficiencies between CPT 64448 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64448 and 76942.

Key Reference Service (KRS) Code Comparison

KRS1: The most typical KRS selected was CPT code 62327 (*Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)*) with 46.77% of the respondents selecting this code. 83% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

KRS2: The most typical KRS selected was CPT code 62325 (*Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT*)) with 14.52% respondents selecting this code. With 89% of the survey respondents that selected this KRS indicated that the surveyed code was identical or more intense.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64448	**Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed**	**1.68**	**0.075**	**43**	**19**	**15**	**9**
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	1.90	0.0866	45	20	15	10
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other	2.20	0.1066	45	20	15	10

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
	solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)						

MPC Codes

Our recommended Work RVU of 1.68 is well bracketed by MPC codes with the similar intra-service time and similar total times and clinically similar and with similar intensities. The two MPC codes are code 20611 with a Work RVU of 1.10 and code 64483 with a Work RVU of 1.90.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting	1.10	0.0791	27	12	10	5
64448	**Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed**	**1.68**	**0.075**	**43**	**19**	**15**	**9**
64483	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level	1.90	0.0816	49	24	15	10

Other Comparison Codes

Societies also reviewed how the recommendation fit in with other codes with similar intra-service time, similar total time, clinically similar and with similar intensities and concluded that this provided further evidence of the appropriateness of the recommendation.

CPT	DESCRIPTOR	RVW	IWPUT	TOTAL TIME	PRE	INTRA	POST
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	1.27	0.0782	35	15	10	10
64448	**Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed**	**1.68**	**0.075**	**43**	**19**	**15**	**9**
10035	Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion	1.70	0.0733	45	20	15	10

Summary

The societies recommend for code 64448 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed)* the following:

Work RVU: 1.68 (25th percentile)

Physician Time

- Pre-Time: 13/1/5 minutes
- Intra-Service Time: 15 minutes
- Post Time: 9 minutes
- Total Time: 43 minutes

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64448

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNAs How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 120564
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization.

Specialty Anesthesiology Frequency 107061 Percentage 88.80 %

Specialty CRNAs Frequency 11936 Percentage 9.90 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 40,188 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty Anesthesiology Frequency 35687 Percentage 88.80 %

Specialty CRNAs Frequency 3979 Percentage 9.90 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64448

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:76942 Tracking Number M22 Original Specialty Recommended RVU: **0.67**
Presented Recommended RVU: **0.67**
Global Period: XXX Current Work RVU: **0.67** RUC Recommended RVU: **0.67**

CPT Descriptor: Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Ultrasonic guidance is utilized for needle placement during a separately reported underlying procedure (eg, biopsy, aspiration, injection).

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review patient order, clinical history, and relevant prior imaging examinations. Confirm appropriateness of imaging guidance and determine appropriate protocol and approach. Discuss with the patient (and family or proxy) the risks and benefits relative to other potential imaging modalities. Discuss the equipment being used and potential for prolonged immobility and repositioning to ensure optimal imaging for guidance and interpretation. Provide instructions for the diagnostic medical sonographer in the ultrasound equipment required, including appropriate transducers, needle guides, and probe covers, as well as the proper settings for the ultrasound equipment. Confirm patient positioning and imaging setup, ensuring the entire area necessary can be imaged and that equipment and patient can be repositioned as needed during sterile procedure (i.e., the field must be clear of impediments to approach and repositioning as needed). The physician dresses in sterile attire.

Description of Intra-Service Work: Supervise and interpret initial sonography of area to be imaged to select appropriate planes of view. Obtain and interpret preliminary images acquired to assess appropriate approach to the target(s), evaluate for unexpected findings, interval changes in target lesion(s), and adjust patient positioning or protocol as needed. Mark skin entry site and prepare in sterile fashion with sterile drape and ultrasound probe cover. Perform intermittent or continuous ultrasound guidance to direct needle to target(s) and reposition, as necessary. Confirm satisfactory needle placement in the target(s). Obtain and interpret post-procedural ultrasound to evaluate for complications. Interpret all images resulting from the study including dedicated review of the target(s) as well as all visualized viscera, vasculature, and soft tissues. Assess for complications or other unexpected findings. Compare to all pertinent available prior studies. Dictate report for medical record.

Description of Post-Service Work: The physician reviews, proofreads, and submits the final report describing the ultrasound guidance procedure, including the final position of the needle/catheter and any procedure-related complications, for the patient's medical record. Communicate the results of the procedure to the referring physician and patient when appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Lauren Golding, MD; Andy Moriarity, MD; David Reece, DO; Carlo Milani, MD; Wesley Ibazebo, MD; Curtis Anderson, MD; Minhaj Khaja,MD					
Specialty Society(ies):	ACR, AAPM&R, SIS, SIR					
CPT Code:	76942					
Sample Size:	1350	**Resp N:**	98			
Description of Sample:	The ACR surveyed a total of 500 members (a random sample of 250 members and a separate random sample of 250 members who perform radiography, ultrasound, and interventional radiology procedures). The AAPM&R surveyed a random sample of 400 individuals, the SIS surveyed a random sample of 250 individuals, and the SIR surveyed a random sample of 200 individuals from their respective memberships.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	49.00	**100.00**	200.00	1000.00
Survey RVW:	0.41	0.80	**1.04**	1.35	78.00
Pre-Service Evaluation Time:			**7.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	10.00	**15.00**	20.00	55.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	76942	**Recommended Physician Work RVU: 0.67**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**5.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
76536	XXX	0.56	**RUC Time**

CPT Descriptor Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
38221	XXX	1.28	**RUC Time**

CPT Descriptor Diagnostic bone marrow; biopsy(ies)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76857	XXX	0.50	**RUC Time**	205,984

CPT Descriptor 1 Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76519	XXX	0.54	**RUC Time**	187,253

CPT Descriptor 2 Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation

Other Reference CPT Code	Global	Work RVU	Time Source
95251	XXX	0.70	**RUC Time**

CPT Descriptor Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 **% of respondents:** 18.3 **%**

Number of respondents who choose 2nd Key Reference Code: 17 **% of respondents:** 17.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 76942	Top Key Reference CPT Code: 76536	2nd Key Reference CPT Code: 38221
Median Pre-Service Time	7.00	4.00	15.00
Median Intra-Service Time	15.00	10.00	20.00
Median Immediate Post-service Time	5.00	4.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**27.00**	**18.00**	**50.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	17%	56%	22%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	33%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	11%	83%

Physical effort required	6%	33%	61%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	11%	83%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	18%	53%	29%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	12%	24%	65%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	12%	88%
Physical effort required	12%	53%	35%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	12%	82%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The Somatic Nerve Injection code family was identified on the October 2021 RUC New and Revised LOI due to the bundling of seven codes (CPT codes 64415, 64416, 64417, 64445, 64446, 64447, 64448) with imaging

guidance. There are three codes which capture the imaging guidance component of the somatic nerve injection procedures.

The imaging guidance codes are comprised of the following:

- **CPT code 76942**: *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*
- **CPT code 77002**: *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)*
- **CPT code 77003**: *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)*

The American College of Radiology (ACR), American Academy of Physical Medicine and Rehabilitation (AAPM&R), Spine Intervention Society (SIS), and Society of Interventional Radiology (SIR) agreed to survey CPT code 76942 for the October 2021 RUC meeting.

Survey Process
The ACR surveyed a total of 500 members (a random sample of 250 members and a separate random sample of 250 members who perform radiography, ultrasound, and interventional radiology procedures). The AAPM&R surveyed a random sample of 400 individuals, the SIS surveyed a random sample of 250 individuals, and the SIR surveyed a random sample of 200 individuals from their respective memberships.

Work RVU and Time Recommendations
The expert panel recommends maintaining the current value at 0.67 work RVU, which is below the survey 25th percentile, and current times of 7 minutes pre-service, 15 minutes intra-service and 5 minutes post-service which match the median survey times.

Key Reference Services
The societies propose the existing wRVU at 0.67 for the surveyed code, which is bracketed by the most commonly chosen key references services, CPT codes 76536 *(Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation)* and 38221 *(Diagnostic bone marrow; biopsy(ies)).* The most commonly chosen key reference code, 76536, is a comparable ultrasound procedure based on the type of imaging performed and the interpretation of the images obtained. Comparatively, the surveyed code typically requires more pre-service time to review the pre-existing images for the needle target and more real-time imaging to guide the needle during the procedure. This contributes to the 5 additional intra-service minutes and overall longer total time, which corresponds to the greater total time for the surveyed code and higher wRVU relative to KRS code 76536. The second most commonly chosen key reference code, 38221, is a biopsy procedure performed without imaging guidance, which has 5 additional minutes of intra-service time and 23 additional minutes of total time, supporting the higher wRVU. The majority of survey respondents rated the surveyed code as “somewhat more” or “much more” intense than each KRS and these responses are well aligned with the survey 25th percentile wRVU of 0.80. However, the specialties are requesting to maintain the current 0.67 wRVU.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	0.56	4	10	4	18	0.038	0.031
76942	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation**	**0.67**	**7**	**15**	**5**	**27**	**0.027**	**0.025**
38221	Diagnostic bone marrow; biopsy(ies)	1.28	15	20	15	50	0.030	0.026

MPC Codes

The surveyed code is bracketed by MPC codes 76519 *(Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation)* and 95251 *(Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report).* MPC code 76519 is an ophthalmic ultrasound code which has 5 minutes less intra-service and total time, with a proportionally lower wRVU and nearly identical IWPUT compared to the proposed value of the surveyed code. MPC code 95251 is an interpretation and reporting of data from a diagnostic test which has identical intra-service time and a slightly higher wRVU. MPC code 76857 *(Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles))* is a radiology ultrasound code which has less intra-service time than the surveyed code and a comparably lower wRVU.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76857	Ultrasound, pelvic (nonobstetric), real time with image documentation; limited or follow-up (eg, for follicles)	0.50	5	7	5	17	0.039	0.029
76519	Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation	0.54	2	10	10	22	0.027	0.025
76942	**Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation**	**0.67**	**7**	**15**	**5**	**27**	**0.027**	**0.025**
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report	0.70	2	15	3	20	0.039	0.035

Summary

In summary, our expert panel recommends maintaining the current value at 0.67 work RVU and current times of 7 minutes pre-service, 15 minutes intra-service and 5 minutes post-service. The recommended value compares favorably with the key reference services and MPC codes, and maintains relativity within the RBRVS.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76942

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty Physical Medicine and Rehabilitation How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 3534798
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This service described by CPT code 76942 is estimated to be provided 3,534,798 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 109121 Percentage 3.08 %

Specialty Interventional Radiology Frequency 28380 Percentage 0.80 %

Specialty Physical Medicine and Rehabilitation Frequency 58291 Percentage 1.64 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,178,266 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 76942 is estimated to be provided 1,178,266 times in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 36374 Percentage 3.08 %

Specialty Interventional Radiology Frequency 9460 Percentage 0.80 %

Specialty Physical Medicine and Rehabilitation Frequency 19430 Percentage 1.64 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Echography/ultrasonography

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 76942

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77002 Tracking Number M23 Original Specialty Recommended RVU: **0.54**
Presented Recommended RVU:
Global Period: ZZZ Current Work RVU: **0.54** RUC Recommended RVU: **0.54**

CPT Descriptor: Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male with hip pain and suspected joint effusion is referred for joint aspiration. Fluoroscopic guidance is used to advance a needle into the joint space, and the joint fluid is aspirated (needle aspiration is reported separately).

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician reviews the patient's history and prior imaging studies to become familiar with the patient's anatomy and plan an appropriate trajectory for the needle placement (including access site, pertinent landmarks, and variant anatomy). Physician obtains informed consent from patient or patient’s proxy. The physician dresses in radiation attire and ensures others in the room have radiation attire. The physician instructs the radiologic technologists on the imaging equipment required, including the proper settings and radiation dose controls for the imaging equipment. The patient is placed on a fluoroscopy table and positioned appropriately, depending on the type of procedure to be performed.

Description of Intra-Service Work: Preliminary fluoroscopy, including angulation of the beam source to image receptor plane, is performed in order to identify the appropriate level and approach for the initial needle placement. The skin entry site is prepped and marked, and sterile drapes are applied. Local anesthetic may be applied. During needle placement, intermittent fluoroscopy and angulation of the x-ray source and receptor are used to confirm the correct approach and the need for needle repositioning or realignment. When the needle position appears correct, radiographic contrast may be injected to confirm the proper position or tissue samples may be acquired and reviewed. If the position is not correct, additional fluoroscopy is used to guide repositioning until the proper position is achieved. Interpret images, as appropriate. Dictate report for medical record. The physician reviews, proofreads, and submits a report that describes the guidance procedure, including the final position of the needle/catheter, for the patient's medical record. Patient dose report will be retained in imaging center records and may be discussed with patient or designated caretaker at patient’s or caretaker’s request. The physician communicates the results of the procedure to the referring physician when appropriate.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021		
Presenter(s):	Lauren Golding, MD; Andy Moriarity, MD; Richard Rosenquist, MD; Neal Cohen, MD; Gordon Morewood, MD; Gregory Polston, MD; Wesley Ibazebo, MD; David Reece, DO; Carlo Milani, MD; Curtis Anderson, MD; Minhaj Khaja, MD		
Specialty Society(ies):	ACR, ASA, AAPM, SIS, AAPM&R, SIR		
CPT Code:	77002		
Sample Size:	2346	**Resp N:**	91
Description of Sample:	The ACR surveyed a total of 500 members (a random sample of 250 members and a separate random sample of 250 members who perform radiography, fluoroscopy, musculoskeletal, neuro imaging, neurointerventional, and interventional radiology procedures). The AAPM&R surveyed a random sample of 400 individuals, the AAPM surveyed a random sample of 500 individuals, the ASA surveyed a random sample of 496 individuals, the SIS surveyed a random sample of 250 individuals, and the SIR surveyed a random sample of 200 individuals from their respective memberships.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	11.00	**50.00**	175.00	5000.00
Survey RVW:	0.30	0.50	**1.00**	1.03	2.00
Pre-Service Evaluation Time:			**6.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	10.00	**15.00**	20.00	55.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	77002	**Recommended Physician Work RVU: 0.54**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**2.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
77001	ZZZ	0.38	**RUC Time**

CPT Descriptor Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
10008	ZZZ	1.18	**RUC Time**

CPT Descriptor Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93923	XXX	0.45	**RUC Time**	440,595

CPT Descriptor 1 Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization

74220	XXX	0.60	**RUC Time**	196,573

CPT Descriptor 2 Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study

Other Reference CPT Code	Global	Work RVU	Time Source
95251	XXX	0.70	**RUC Time**

CPT Descriptor Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 22 **% of respondents:** 24.1 **%**

Number of respondents who choose 2nd Key Reference Code: 15 **% of respondents:** 16.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 77002	**Top Key Reference CPT Code:** 77001	**2nd Key Reference CPT Code:** **10008**
Median Pre-Service Time	2.00	2.00	0.00
Median Intra-Service Time	15.00	15.00	20.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**17.00**	**17.00**	**20.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	9%	59%	18%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	68%	27%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	64%	32%
Physical effort required	5%	64%	32%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	14%	64%	23%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	7%	7%	60%	20%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	53%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	60%	20%
Physical effort required	7%	73%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	47%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background
The Somatic Nerve Injection code family was identified on the October 2021 RUC New and Revised LOI due to the bundling of seven codes (CPT codes 64415, 64416, 64417, 64445, 64446, 64447, 64448) with imaging guidance. There are three codes which capture the imaging guidance component of the somatic nerve injection procedures.

The imaging guidance codes include the following:

- **CPT code 76942**: *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*
- **CPT code 77002**: *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)*
- **CPT code 77003**: *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)*

The American College of Radiology (ACR), American Academy of Physical Medicine and Rehabilitation (AAPM&R), American Academy of Pain Medicine (AAPM), American Society of Anesthesiologists (ASA), Spine Intervention Society (SIS), and Society of Interventional Radiology (SIR) agreed to survey CPT code 77002 for the October 2021 RUC meeting.

Survey Process
The ACR surveyed a total of 500 members (a random sample of 250 members and a separate random sample of 250 members who perform radiography, fluoroscopy, musculoskeletal, neuro imaging, neurointerventional, and interventional radiology procedures). The AAPM&R surveyed a random sample of 400 individuals, the AAPM surveyed a random sample of 500 individuals, the ASA surveyed a random sample of 496 individuals, the SIS surveyed a random sample of 250 individuals, and the SIR surveyed a random sample of 200 individuals from their respective memberships.

History of 77002 and 77003: Pre-Service Time
CPT codes 77002 and 77003 were once XXX codes, but CMS felt that the vignettes and parentheticals for the codes were consistent with that of add-on codes and requested that the societies survey them as ZZZ codes in October 2015.

In October 2015, the existing times for both 77002 and 77003 were 7 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service, so the societies recommended the current times for all 3 codes, including CPT code 77001, at the October 2015 RUC meeting. The RUC recommended reducing the pre-service time to 2 minutes instead of 7 minutes. The 2 minutes of pre-service time is based on the difference in pre-service positioning time between the epidural injection without imaging guidance (CPT code 62320) and with imaging guidance (CPT code 62321) codes. This is the primary reason that the societies were allotted pre-service time for these add-on codes.

Work RVU and Time Recommendations
The expert panel recommends maintaining the current value at 0.54 work RVU and current times of 2 minutes pre-service and 15 minutes intra-service.

Reference Service List

During the survey process of the fluoroscopic guidance codes (CPT codes 77002 and 77003), a multi-specialty Qualtrics survey was launched mistakenly using a draft version of the RSL instead of the final version.. Of the six specialties surveying this code 4 societies used an old version of the RSL and 2 societies used the final version of the RSL. All involved societies communicated this issue to AMA staff, specifically to Mike Morrow who is aware of the situation. The main differences between the two RSL are: a) the old RSL includes CPT codes 64421, 75565, and 76937 which the final RSL does not include and b) the final RSL includes CPT codes 76983 and 78835 which the old RSL does not include.

Based on the helpful input from Mike Morrow, the societies believe that this issue does not significantly impact the survey data and thus, the survey data is valid and can be used for our recommendations to the RUC for the following reasons: a) the top two KRS codes chosen by the surveyees were in both the old version and the final version of the RSL b) Two of the codes that were only in the old RSL version were not selected by the surveyees at all (CPT codes 75565 and 76937) and the other code (CPT 64421) was selected by only 5 surveyees. We do not believe this impacted the final KRS selections.

To note, CPT code 64421 is currently being reviewed by the RUC for this meeting as this code is included in this tab for the Somatic Nerve Injection code family. Therefore, CPT code 64421 would be invalid to use on this RSL.

Key Reference Services

The most commonly chosen key reference service was CPT code 77001 *(Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure))*, selected by 24% of respondents, and has identical pre-service, intra-service, and total time compared to surveyed code 77002. The majority of survey respondents (59%) felt that KRS code 77001 had identical overall intensity and complexity compared to the surveyed code. CPT code 77002 pertains to fluoroscopic guidance of a needle during a percutaneous procedure and typically may involve contrast injection or tissue sampling to aid in confirming the position. Comparatively, CPT code 77001 involves fluoroscopic guidance through an existing venous access.

The second most commonly chosen key reference service was CPT code 10008 *(Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure))*, an ultrasound guidance code that typically involves tissue sampling. This KRS code was selected by 16% of respondents and has 20 minutes of total time and a proportionally higher wRVU. The majority of the survey respondents (60%) indicated that KRS code 10008 had an identical overall intensity and complexity compared to the surveyed code.

A third key reference code was also chosen, CPT code 64484, *(Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure))*, as 16% of the survey respondents selected this code. Similar to CPT code 77002, CPT code 64484 is a fluoroscopic guidance add-on code for an additional injection performed after the base procedure, with a significantly higher IWPUT due to the intensity of positioning a needle in the spinal nerve foramen. This provides an appropriate comparison to the surveyed code, as 77002 involves a more typical needle placement within a large joint.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT

77001	Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	0.38	2	15		17	0.022	0.022
77002	**Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)**	**0.54**	**2**	**15**		**17**	**0.033**	**0.032**
64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	1.00		10		10	0.100	0.100
10008	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)	1.18		20		20	0.059	0.059

MPC Codes

Prior to 2015, the surveyed code was an XXX code and there are limited ZZZ codes on the MPC list for comparison purposes. The surveyed code is closely bracketed by two radiology XXX codes, MPC codes 93923 *(Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more, or single level study with provocative functional maneuvers)* and 74220 *(Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study).* MPC code 93923 has 5 minutes less intra-service time and 1 minute less total time, with a proportionally lower wRVU and nearly identical IWPUT, compared to the surveyed code.

MPC code 74220 is a radiology procedure with 5 minutes less intra-service time and greater wRVU and IWPUT compared to the surveyed code. MPC code 74220 typically involves much more repositioning of the patient during real-time examination and concurrent examination of anatomic structures following contrast administration while in comparison, the surveyed code is a focused on a single area of anatomy.

Lastly, the surveyed code is compared to MPC code 95251, which has identical intra-service time and slightly more total time, resulting in a similar IWPUT and proportionally greater wRVU compared to the surveyed code.

CPT Code	Descriptor	Work RVU	Global Period	Pre	Intra	Post	Total Time	IWPUT	WPUT
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more, or single level study with provocative functional maneuvers	0.45	XXX	3	10	3	16	0.032	0.028
77002	**Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)**	**0.54**	**ZZZ**	**2**	**15**		**17**	**0.033**	**0.032**
74220	Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study	0.60	XXX	3	10	3	16	0.047	0.038
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report	0.70	XXX	2	15	3	20	0.040	0.035

Summary

In summary, our expert panel recommends maintaining the current value at 0.54 work RVU and survey median times of 2 minutes pre-service positioning and 15 minutes intra-service. The recommended value compares favorably with the key reference services and MPC codes, and maintains relativity within the RBRVS.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77002

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Anesthesiology How often? Commonly

Specialty Pain Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 1,048,554
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This service described by CPT code 77002 is estimated to be provided 1,048,554 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 241239 Percentage 23.00 %

Specialty Anesthesiology Frequency 83742 Percentage 7.98 %

Specialty Pain Medicine Frequency 108250 Percentage 10.32 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 349,518 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 77002 is estimated to be provided 349,518 times in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 80413 Percentage 23.00 %

Specialty Anesthesiology Frequency 27914 Percentage 7.98 %

Specialty Pain Medicine Frequency 36083 Percentage 10.32 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Imaging/procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77002

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:77003 Tracking Number M24 Original Specialty Recommended RVU: **0.60**
Presented Recommended RVU:
Global Period: ZZZ Current Work RVU: **0.60** RUC Recommended RVU: **0.60**

CPT Descriptor: Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Fluoroscopic guidance is used for needle placement during a separately reported underlying procedure involving the spine (eg, biopsy, aspiration, injection).

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The physician reviews the patient's history and prior imaging studies to become familiar with the patient's spine anatomy (e.g., numbering of levels, anatomic variants, prior surgery, pathology). Physician obtains informed consent from patient or patient’s proxy. The physician dresses in radiation attire and ensures others in the room have radiation attire. The physician instructs the radiologic technologists in the imaging equipment required, including the proper settings and radiation dose controls for the imaging equipment. The patient is placed on a fluoroscopy table in the prone, decubitus, or prone oblique position, depending on the type of injection to be performed.

Description of Intra-Service Work: Preliminary fluoroscopy is performed, including angulation of the beam source to image receptor plane to identify the appropriate level and approach for initial needle placement. The skin entry site is prepped and marked, and sterile drapes are applied. Local anesthetic may be applied. During needle/catheter placement, intermittent fluoroscopy and angulation of the x-ray source and receptor are used to confirm the correct approach and need for needle repositioning or realignment. When the needle position appears correct, radiographic contrast is injected to confirm proper position. If the position is not correct, additional fluoroscopy during repositioning is provided until proper position is achieved. If a catheter is to be placed, additional fluoroscopic guidance is provided during and after catheter positioning to confirm proper positioning and perform additional contrast injections, as necessary. Interpret images, as appropriate. Dictate report for medical record. The physician reviews, proofreads, and submits a report that describes the guidance procedure, including the final position of the needle/catheter, for the patient's medical record. Patient dose report will be retained in imaging center records and may be discussed with patient or designated caretaker at patient’s or caretaker’s request. The physician communicates the results of the procedure to the referring physician when appropriate.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Lauren Golding, MD; Andy Moriarity, MD; Richard Rosenquist, MD; Neal Cohen, MD; Gordon Morewood, MD; Gregory Polston, MD; Wesley Ibazebo, MD; Curtis Anderson, MD; Minhaj Khaja, MD					
Specialty Society(ies):	ACR, ASA, AAPM, SIS, SIR					
CPT Code:	77003					
Sample Size:	1946	**Resp N:**	82			
Description of Sample:	The ACR surveyed a total of 500 members (a random sample of 250 members and a separate random sample of 250 members who perform radiography, fluoroscopy, musculoskeletal, neuro imaging, neurointerventional, and interventional radiology procedures). The AAPM surveyed a random sample of 500 individuals, the ASA surveyed a random sample of 496 individuals, the SIS surveyed a random sample of 250 individuals, and the SIR surveyed a random sample of 200 individuals from their respective memberships.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**50.00**	200.00	7000.00
Survey RVW:	0.38	0.76	**1.03**	1.20	2.10
Pre-Service Evaluation Time:			**9.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	10.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	77003	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**2.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64484	ZZZ	1.00	**RUC Time**

CPT Descriptor Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64491	ZZZ	1.16	**RUC Time**

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74220	XXX	0.60	**RUC Time**	196,573

CPT Descriptor 1 Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95251	XXX	0.70	**RUC Time**	248,288

CPT Descriptor 2 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
99407	XXX	0.50	**RUC Time**

CPT Descriptor Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 30 **% of respondents:** 36.5 **%**

Number of respondents who choose 2nd Key Reference Code: 22 **% of respondents:** 26.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 77003	Top Key Reference CPT Code: 64484	2nd Key Reference CPT Code: **64491**
Median Pre-Service Time	2.00	0.00	0.00
Median Intra-Service Time	15.00	10.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**17.00**	**10.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	3%	83%	13%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	67%	27%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	77%	17%
Physical effort required	0%	87%	13%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	70%	20%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	5%	9%	55%	23%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	14%	64%	23%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	77%	9%
Physical effort required	5%	77%	18%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	55%	41%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background
The Somatic Nerve Injection code family was identified on the October 2021 RUC New and Revised LOI due to the bundling of seven codes (CPT codes 64415, 64416, 64417, 64445, 64446, 64447, 64448) with imaging guidance. There are three codes which capture the imaging guidance component of the somatic nerve injection procedures.

The imaging guidance codes include the following:

- **CPT code 76942**: *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation*
- **CPT code 77002**: *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)*
- **CPT code 77003**: *Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)*

The American College of Radiology (ACR), American Academy of Pain Medicine (AAPM), American Society of Anesthesiologists (ASA), Spine Intervention Society (SIS), and Society of Interventional Radiology (SIR) agreed to survey CPT code 77003 for the October 2021 RUC meeting.

Survey Process
The ACR surveyed a total of 500 members (a random sample of 250 members and a separate random sample of 250 members who perform radiography, fluoroscopy, musculoskeletal, neuro imaging, neurointerventional, and interventional radiology procedures). The AAPM surveyed a random sample of 500 individuals, the ASA surveyed a random sample of 496 individuals, the SIS surveyed a random sample of 250 individuals, and the SIR surveyed a random sample of 200 individuals from their respective memberships.

History of 77002 and 77003: Pre-Service Time
CPT codes 77002 and 77003 were once XXX codes, but CMS felt that the vignettes and parentheticals for the codes were consistent with that of add-on codes and requested that the societies survey them as ZZZ codes in October 2015.

In October 2015, the existing times for both 77002 and 77003 were 7 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service in 2015, so the societies recommended the current times for all 3 codes, including CPT code 77001, at the October 2015 meeting. The RUC recommended reducing the pre-service time to 2 minutes instead of 7 minutes. The 2 minutes of pre-service time is based on the difference in pre-service positioning time between the epidural injection without imaging guidance (CPT code 62320) and with imaging guidance (CPT code 62321) codes. This is the primary reason that the societies were allotted pre-service time for these add-on codes.

Work RVU and Time Recommendations
The expert panel recommends maintaining the current value at 0.60 work RVU and current times of 2 minutes pre-service and 15 minutes intra-service.

Reference Service List
During the survey process of the fluoroscopic guidance codes (CPT codes 77002 and 77003), a multi-specialty Qualtrics survey was launched mistakenly using a draft version of the RSL instead of the final version. Of the five specialties surveying this code, 4 societies used an old version of the RSL and 2 societies used the final version of the RSL. All involved societies communicated this issue to AMA staff, specifically to Mike Morrow who is aware of the situation. The main differences between the two RSL are: a) the old RSL includes CPT codes 64421, 75565, and 76937 which the final RSL does not include and b) the final RSL includes CPT codes 76983 and 78835 which the old RSL does not include.

Based on the helpful input from Mike Morrow, the societies believe that this issue does not significantly impact the survey data and thus, the survey data is valid and can be used for the following reasons: a) the top two KRS codes chosen by the surveyees were in both the old version and the final version of the RSL b) Two of the codes that were only in the old version were not selected by the surveyees at all (CPT codes 75565 and 76937) and the other code (CPT 64421) was selected by only 3 surveyees. We do not believe this impacted the final KRS selections.

To note, CPT code 64421 is currently being reviewed by the RUC for this meeting as this code is included in this tab for the Somatic Nerve Injection code family. Therefore, CPT code 64421 would be invalid to use on this RSL.

Key Reference Services

The most commonly chosen key reference service code, 64484 *(Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure))* has 5 minutes less intra-service time and a higher IWPUT compared to the surveyed code, 77003. KRS code 64484 was chosen by 37% of survey respondents, with 83% of this subset indicating that the KRS code had identical overall intensity and complexity compared to the surveyed code.

The second most commonly chosen key reference code was CPT code 64491 *(Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure))*, which has identical intra-service time and a higher IWPUT compared to the surveyed code. KRS code 64491 was chosen by 27% of respondents, with 55% of this subset indicating that the code had identical overall intensity and complexity compared to the survey code.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
77003	**Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)**	**0.60**	**2**	**15**		**17**	**0.037**	**0.035**
64484	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	1.00		10		10	0.100	0.100
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)	1.16		15		15	0.077	0.077

MPC Codes

Prior to 2015, CPT code 77003 was an XXX code and there are limited ZZZ codes on the MPC list for comparison purposes. In comparison to MPC code 74220 *(Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study))*, the

CPT code 77003 has an identical wRVU, and 1 minute more of total time. The lower IWPUT of the surveyed code is proportional due to the differences intra-service time between the two codes.

Additionally, the surveyed code also compares well to MPC code 95251 *(Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report))*, which has an identical intra-service time and slightly more total time, resulting in a similar IWPUT and proportionally greater wRVU, compared to 77003.

Lastly, the surveyed code compares favorably to MPC code 99407 *(Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes))*, which has identical intra-service time and 2 minutes less of total time, compared to the surveyed code, resulting in a similar IWPUT and proportionally lower wRVU.

CPT Code	Descriptor	Work RVU	Global Period	Pre	Intra	Post	Total Time	IWPUT	WPUT
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes	0.50	XXX		15		15	0.033	
77003	**Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)**	**0.60**	**ZZZ**	**2**	**15**		**17**	**0.037**	**0.035**
74220	Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study	0.60	XXX	3	10	3	16	0.047	
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report	0.70	XXX	2	15	3	20	0.040	

Summary

In summary, our expert panel recommends maintaining the current value at 0.60 work RVU and survey median times of 2 minutes pre-service positioning and 15 minutes intra-service. The recommended value compares favorably with the key reference services and MPC codes, and maintains relativity within the RBRVS.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.

- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 77003

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty Interventional Radiology How often? Commonly

Specialty Anesthesiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 22,020
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This service described by CPT code 77003 is estimated to be provided 22,020 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 15006 Percentage 68.14 %

Specialty Interventional Radiology Frequency 1699 Percentage 7.71 %

Specialty Anesthesiology Frequency 940 Percentage 4.26 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,340
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 77003 is estimated to be provided 7,340 times in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 5002 Percentage 68.14 %

Specialty Interventional Radiology Frequency 566 Percentage 7.71 %

Specialty Anesthesiology Frequency 313 Percentage 4.26 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:

Imaging

BETOS Sub-classification:
Imaging/procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 77003

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Somatic Nerve Injections

TAB: 5 (64415-64417 and 64445-64448)

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	64486	0	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by		29	0.078	0.036			1.27			35	5	5	5			10			10	0	0	8	50	600
2nd REF	62323	0	injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution),		25	0.080	0.040			1.80			45	10	5	5			15			10					
CURRENT	64415	0	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus	Oct-18		0.065	0.034			1.35			40	13	1	4			12			10					
CURRENT	76942	0	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging	Oct-18		0.027	0.025			0.67			27	7	0	0			15			5					
CURRENT	Combined (64415 + 76942)	0				0.097	0.047			2.02			43	13	1	4			15			10					
SVY	64415	0	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed		86	0.114	0.043	0.90	1.50	1.80	2.00	5.00	42	17	4	4	3	6	10	15	180	7	0	18	48	119	550
REC	64415	0	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed			0.100	0.043			1.50			35	13	1	4			10			7					

*Combined intra time reflects efficiencies between CPT 64415 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64415 and 76942.

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	62325	0	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or		28	0.107	0.049			2.20			45	10	5	5			15			10	0	0	5	50	1000
2nd REF	62327	0	continuous infusion or intermittent bolus, of diagnostic or		27	0.087	0.042			1.90			45	10	5	5			15			10					
CURRENT	64416	0	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including	Oct-18		0.045	0.030			1.48			49	13	1	5			20			10					
CURRENT	76942	0	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging	Oct-18		0.027	0.025			0.67			27	7	0	0			15			5					
CURRENT	Combined (64416 + 76942)	0				0.068	0.041			2.15			52	13	1	5			23			10					
SVY	64416	0	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including		79	0.078	0.036	1.00	1.80	2.00	2.20	6.00	55	20	5	5	0	12	15	20	180	10	0	0	10	28	400
REC	64416	0	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed			0.081	0.041			1.80			44	13	1	5			15			10					

*Combined intra time reflects efficiencies between CPT 64416 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64416 and 76942.

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	64486	0	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by		29	0.078	0.036			1.27			35	5	5	5			10			10	0	0	11	50	600
2nd REF	62323	0	injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution),		18	0.080	0.040			1.80			45	10	5	5			15			10					
CURRENT	64417	0	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve	Oct-18		0.070	0.033			1.27			38	13	1	4			10			10					
CURRENT	76942	0	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging	Oct-18		0.027	0.025			0.67			27	7	0	0			15			5					
CURRENT	Combined (64417 + 76942)	0				0.105	0.047			1.94			41	13	1	4			13			10					
SVY	64417	0	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed		79	0.083	0.034	0.90	1.31	1.60	1.90	5.00	47	18	5	4	3	7	10	15	180	10	0	2	10	50	550
REC	64417	0	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed			0.074	0.034			1.31			38	13	1	4			10			10					

*Combined intra time reflects efficiencies between CPT 64417 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64417 and 76942.

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	64486	0	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by		28	0.078	0.036			1.27			35	5	5	5			10			10	0	0	15	50	1000
2nd REF	62323	0	injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution),		13	0.080	0.040			1.80			45	10	5	5			15			10					
CURRENT	64445	0	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve	Oct-18		0.070	0.042			1.00			24	7	1	1			10			5					
CURRENT	76942	0	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging	Oct-18		0.027	0.025			0.67			27	7	0	0			15			5					
CURRENT	Combined (64445 + 76942)	0				0.105	0.062			1.67			27	7	1	1			13			5					
SVY	64445	0	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed		76	0.115	0.047	0.50	1.39	1.60	1.83	2.88	34	12	4.5	3	2	5	10	13	60	5	0	12	26	63	400
REC	64445	0	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed			0.109	0.058			1.39			24	7	1	1			10			5					

*Combined intra time reflects efficiencies between CPT 64445 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64445 and 76942.

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	62327	0	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or		29	0.087	0.042			1.90			45	10	5	5			15			10	0	0	20	65	750
2nd REF	62325	0	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or		11	0.107	0.049			2.20			45	10	5	5			15			10					
CURRENT	64446	0	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter	Oct-18		0.058	0.034			1.36			40	13	1	5			15			6					
CURRENT	76942	0	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging	Oct-18		0.027	0.025			0.67			27	7	0	0			15			5					
CURRENT	Combined (64446 + 76942)	0				0.086	0.047			2.03			43	13	1	5			18			6					
SVY	64446	0	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter		60	0.078	0.037	1.20	1.75	1.90	2.03	3.50	51	16.5	5	5	2	11	15	19	120	9.5	0	2	10	21	300
REC	64446	0	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed			0.078	0.040			1.75			44	13	1	5			15			10					

*Combined intra time reflects efficiencies between CPT 64446 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64446 and 76942.

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	64486	0	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s), anesthetic or analgesic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that		32	0.078	0.036			1.27			35	5	5	5			10			10	0	1	15	50	1000
2nd REF	64493	0			12	0.066	0.036			1.52			42	7	5	5			15			10					
CURRENT	64447	0	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve	Oct-18		0.112	0.041			1.10			27	12	1	3			6			5					
CURRENT	76942	0	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Oct-18		0.027	0.025			0.67			27	7	0	0			15			5					
CURRENT	Combined (64447 + 76942)	0				0.149	0.059			1.77			30	12	1	3			9			5					
SVY	64447	0	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed		76	0.128	0.048	0.95	1.34	1.51	1.80	2.83	31.5	12.5	3	3	2	5	8	10	60	5	0	12	30	71	300
REC	64447	0	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed			0.114	0.046			1.34			29	12	1	3			8			5					

*Combined intra time reflects efficiencies between CPT 64447 and imaging (76942), leading to only a 3 minute increase in total time when combined. Combined RVW is the sum of the RVW for 64447 and 76942.

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	62327	0	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or		29	0.087	0.042			1.90			45	10	5	5			15			10	0	0	10	50	750
2nd REF	62325	0	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or		9	0.107	0.049			2.20			45	10	5	5			15			10					
CURRENT	64448	0	Injection(s), anesthetic agent(s) and/or steroid, femoral nerve, continuous infusion by catheter (including catheter	Oct-18		0.071	0.037			1.41			38	13	1	5			13			6					
CURRENT	76942	0	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	Oct-18		0.027	0.025			0.67			27	7	0	0			15			5					
CURRENT	Combined (64448 + 76942)	0				0.099	0.051			2.08			41	13	1	5			16			6					
SVY	64448	0	Injection(s), anesthetic agent(s) and/or steroid, femoral nerve, continuous infusion by catheter (including catheter		62	0.080	0.038	1.00	1.68	1.90	2.00	5.00	49.5	16	4.5	5	2	10	15	17	120	9	0	2	10	20	300
REC	64448	0	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed			0.075	0.039			1.68			43	13	1	5			15			9					

ISSUE: Somatic Nerve Injections

TAB: 5 (64400-64405, 64408, 64418-64435, 64449-64455)

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total Time	PRE-TIME			INTRA-TIME				IMMD	SURVEY EXPERIENCE			
								MIN	25th	MED	75th	MAX		EVAL	POSIT	SDW	MIN	25th	MED	75th MAX	POST	MIN	25th	MED	75th MAX
RUC	64400	0	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	Oct-18		0.117	0.050			1.00			20	7	1	1			6		5				
RUC	64405	0	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	Apr-17		0.139	0.059			0.94			16	5	1	0			5		5				
RUC	64408	0	Injection(s), anesthetic agent(s) and/or steroid; vagus nerve	Oct-18		0.113	0.045			0.90			20	7	3	0			5		5				
RUC	64418	0	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	Apr-16		0.065	0.034			1.10			32	6	3	3			10		10				
RUC	64420	0	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	Oct-18		0.071	0.035			1.18			34	13	1	5			10		5				
RUC	64421	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedure)	Oct-18		0.060	0.060			0.60			10						10						
RUC	64425	0	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	Oct-18		0.081	0.048			1.19			25	7	1	1			11		5				
RUC	64430	0	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve	Oct-18		0.048	0.027			1.15			43	13	5	5			10		10				
RUC	64435	0	Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve	Oct-18		0.083	0.038			0.75			20	7	3	0			5		5				
RUC	64449	0	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	Oct-18		0.077	0.041			1.55			38	13	1	5			14		5				
RUC	64450	0	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	Oct-18		0.090	0.039			0.75			19	7	1	1			5		5				
RUC	64451	0	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	Jan-19		0.061	0.034			1.52			45	17	1	5			15		7				
RUC	64454	0	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	Jan-19		0.047	0.030			1.52			51	17	1	5			18		10				
RUC	64455	0	Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)	Apr-17		0.093	0.036			0.75			21	5	1	5			5		5				

Affirm previous RUC recommendations

SS Rec Summary

ISSUE: Imaging Guidance

TAB: 5

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	76536	XXX	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation	Apr-09	18	0.038	0.031			0.56			18	4					10			4					
2nd REF	38221	XXX	Diagnostic bone marrow; biopsy(ies)	Apr-16	17	0.030	0.026			1.28			50	15					20			15					
RUC	76942	XXX	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization	Apr-14		0.027	0.025			0.67			27	7					15			5					
SVY - Combined	76942	XXX	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization	Oct-21	98	0.051	0.039	0.41	0.80	1.04	1.35	78.00	27	7			4	10	15	20	55	5	0	49	100	200	1000
REC	76942	XXX	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation			0.027	0.025			0.67			27	7					15			5					

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	77001	ZZZ	Fluoroscopic guidance for central venous access device placement, replacement (catheter	Oct-15	22	0.022	0.022			0.38			17	2					15								
2nd REF	10008	ZZZ	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary	Oct-17	15	0.059	0.059			1.18			20						20								
2nd REF	64484	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to	Oct-09	15	0.100	0.100			1.00			10						10								
CURRENT	77002	ZZZ	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization	Oct-15		0.033	0.032			0.54			17	2					15								
SVY - Combined	77002	ZZZ	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization	Oct-21	91	0.050	0.038	0.30	0.50	1.00	1.03	2.00	26	6			2	10	15	20	55	5	0	11	50	175	5000
REC	77002	ZZZ	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)			0.033	0.032			0.54			17	2					15								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	64484	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each	Oct-09	30	0.100	0.100			1.00			10						10								
2nd REF	64491	ZZZ	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image	Apr-09	22	0.077	0.077			1.16			15						15								
CURRENT	77003	ZZZ	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous	Oct-15		0.037	0.035			0.60			17	2					15								
SVY - Combined	77003	ZZZ	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous	Oct-21	82	0.048	0.036	0.38	0.76	1.03	1.20	2.10	29	9			3	10	15	20	60	5	0	10	50	200	7000
REC	77003	ZZZ	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)			0.037	0.035			0.60			17	2					15								

FACILITY DIRECT PE INPUTS **CPT CODE(S):** 64415, 64417, 64445, 64447
SPECIALTY SOCIETY(IES): ASA, ASIPP
PRESENTER(S): Richard Rosenquist, MD; Gordon Morewood, MD; Michael Lubrano, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed	000
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed	000
64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed	000
64447	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64415	A 66-year-old female will undergo surgery on her shoulder and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A brachial plexus block with ultrasound guidance is performed to relieve her pain and improve her function.
64417	A 68-year-old male will undergo surgery on his arm and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. An axillary nerve block with ultrasound guidance is performed to relieve his pain and improve his function.
64445	A 25-year-old female will undergo surgery for a right trimalleolar fracture open reduction and fixation and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A sciatic nerve block with ultrasound guidance is performed to relieve her pain and improve her function.
64447	A 30-year-old male will undergo surgery for a right anterior cruciate ligament repair and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A femoral nerve block with ultrasound guidance is performed to manage post-operative pain and improve his function.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The specialty societies convened an expert panel of advisors from the presenting specialties via telephone to discuss recommendations for practice expense for codes 64415, 64417, 64445, and 64447. The panel reviewed existing inputs for these codes and considered any necessary modifications.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The expert panel used the existing inputs for codes 64415, 64417, 64445, 64447 and 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device*), as reference for the new recommendations.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

3. Is this code(s) typically reported with an E/M service?

No

4. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

N/A

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

For codes 64415, 64417, 64445, 64447 the clinical staff coordinates pre-surgery services (including test results; schedules space and equipment in facility and completes pre-procedure phone calls and prescriptions.

   b. Service period (includes pre, intra and post):

N/A

   c. Post-service period:

N/A

9. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):

10. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

11. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

No

15. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

18. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitude D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

19. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time)*. If you have selected "other formula" for any of the equipment please explain here:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:
    N/A

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:
    N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition to those revisions, please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 64415, 64417, 64445, 64447

SPECIALTY SOCIETY(IES): ASA, ASIPP

PRESENTER(S): Richard Rosenquist, MD; Gordon Morewood, MD; Michael Lubrano, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed	000
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed	000
64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed	000
64447	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed	000

Vignette(s) (*vignette required even if PE only code(s)*):

CPT Code	Vignette
64415	A 66-year-old female will undergo surgery on her shoulder and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A brachial plexus block with ultrasound guidance is performed to relieve her pain and improve her function.
64417	A 68-year-old male will undergo surgery on his arm and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. An axillary nerve block with ultrasound guidance is performed to relieve his pain and improve his function.
64445	A 25-year-old female will undergo surgery for a right trimalleolar fracture open reduction and fixation and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A sciatic nerve block with ultrasound guidance is performed to relieve her pain and improve her function.
64447	A 30-year-old male will undergo surgery for a right anterior cruciate ligament repair and the surgeon consults the anesthesiologist for opioid sparing postoperative pain management. A femoral nerve block with ultrasound guidance is performed to manage post-operative pain and improve his function.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The specialty societies convened an expert panel of advisors from the presenting specialties via telephone to discuss recommendations for practice expense for codes 64415, 64417, 64445, and 64447. The panel reviewed existing inputs for these codes and considered any necessary modifications.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

NONFACILITY DIRECT PE INPUTS
CPT CODE(S): 64415, 64417, 64445, 64447
SPECIALTY SOCIETY(IES): ASA, ASIPP
PRESENTER(S): Richard Rosenquist, MD; Gordon Morewood, MD; Michael Lubrano, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

The expert panel used the existing inputs for codes 64415, 64417, 64445, 64447 and 76942 (*Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device*), as reference for the new recommendations.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see the *Billed Together* tab in the RUC Database)

   No

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see the *Billed Together* tab in the RUC Database)

Code	NF Dominant Provider	% Dominant Provider in NF	All Sites
64415	Neurology	36.5%	Anesthesiology is 87.7%
64417	Neurology	46.1%	Anesthesiology is 75.2%
64445	Family Medicine	36%	Anesthesiology is 37.1%
64447	Family Medicine	57%	Anesthesiology is 75.9%

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

   N/A

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

   N/A

8. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

9. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

For codes 64415, 64417, 64445 and 64447 we are requesting 5 minutes. Typically the following vitals are taken: Heart rate , blood pressure , pulse ox, temp and EKG baseline or rhythm strip

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period: 64415, 64417, 64445 and 64447

During the pre-service period the clinical staff completes pre-procedure phone calls and prescriptions and confirms availability of prior imaging studies.

    b. Service period (includes pre, intra and post):

Pre Time During the pre-time service period the clinical staff greets patient, provides gowning and ensures appropriate medical records are available; obtains vital signs; provides education/obtains consent; prepares room, equipment and supplies; and prepares room setup, initial positioning and monitors patient (standard times are requested) Intra Time Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure. (100% of physician time) Post Time During the post-time the clinical staff monitors the patient, cleans the room, checks dressings, QCs images in PACs, reviews examination with physician, scans exam documents into PACs, and reviews home care instructions and coordinates any prescriptions (standard times are requested)

    c. Post-service period:

N/A

11. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

The clinical staff time is 100% linked to the physician work time for the injection and imaging guided portion of the procedure.

12. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
    N/A

13. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):
    N/A

14. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
    N/A

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:
    N/A

18. Are you recommending a PE supply pack for this recommendation? **Yes** or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
    SA041 – pack, basic injection
    SA048 – minimum multi-specialty visit

19. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

DESCRIPTION	Code	Unit	Item Qty	Unit price
pack, basic injection	**SA041**	**pack**		**11.365**
applicator, sponge-tipped		item	3	
bandage, strip 0.75in x 3in		item	1	
cap, surgical		item	1	

drape, sterile barrier 16in x 29in		item	1	
drape, sterile, for Mayo stand		item	1	
gauze, sterile 4in x 4in		item	2	
gloves, sterile		pair	2	
gown, staff, impervious		item	1	
gown, surgical, sterile		item	1	
lidocaine 1%-2% inj (Xylocaine)		ml	5	
mask, surgical		item	1	
needle, 18-27g		item	2	
povidone soln (Betadine)		ml	10	
syringe 3ml		item	1	
underpad 2ftx3ft (Chux)		item	1	

DESCRIPTION	**Code**	**Unit**	**Item Qty**	**Unit price**
pack, minimum multi-specialty visit	**SA048**	**pack**		**4.0507**
paper, exam table		foot	7	
gloves, non-sterile		pair	2	
gown, patient		item	1	
pillow case		item	1	
cover, thermometer probe		item	1	

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

22. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

23. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time)*. If you have selected "other formula" for any of the equipment please explain here:

- EQ184 – (nerve stimulator (eg, for nerve block)

- 64445 only
- Formula: Default

- EQ011 – (ECG, 3-channel (with SpO2, NIBP, temp, resp))
  - Formula: Other (During the procedure and during monitoring time)
- EQ250 – (ultrasound unit, portable)
  - Formula: Default
- ED050 - Technologist PACS workstation
  - Formula: PAC
- EF023 – Table, exam
  - Formula: Default
- EF015 – Mayo stand
  - Formula: Default

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)
NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 64415, 64417, 64445, 64447

SPECIALTY SOCIETY(IES): ASA, ASIPP

PRESENTER(S): Richard Rosenquist, MD; Gordon Morewood, MD; Michael Lubrano, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

FACILITY DIRECT PE INPUTS **CPT CODE(S): 64400, 64405, 64408, 64420, 64425, 64430, 64435, 64449, 64450, 64451, 64454, ___**

SPECIALTY SOCIETY(IES):__AAN, AAPM, AAPM&R, APMA, ASA, NANS, SIS_____

PRESENTER(S):__Richard Rosenquist, MD; Gordon Morewood, MD; Gregory Poston, MD; Wesley Ibazebo, MD; Carlo Milani, MD; Damean Freas, DO; Brooke Bisbee, DPM_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular	000
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	000
64408	Injection(s), anesthetic agent(s) and/or steroid; vagus nerve	000
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	000
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	000
64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve	
64435	Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve	000
64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	000
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	000
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	000
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64400	A patient with a normal neurologic examination reports of headaches that include pain in one or more branches of the trigeminal nerve (ophthalmic, maxillary, or mandibular). An injection of local anesthetic with or without steroid is performed for nerve blockade.
64405	A patient with frequent headaches and a normal neurological examination has tenderness over the left occipital notch, where palpation triggers pain. For both diagnostic and therapeutic purposes, an injection of local anesthetic and anti-inflammatory is recommended.
64408	A 55-year-old female presents with a neurogenic cough. Injection of an anesthetic agent to the vagus nerve is performed.
64420	A 48-year-old female has a two-year history of rib pain that is interfering with her ability to complete ADLs. She has had poor control of her pain despite multiple medication trials and PT. Due to her persistent, debilitating pain, a trial of intercostal nerve block is scheduled to relieve her pain and improve her function.
64425	A 48-year-old male has a three-year history of pain in his groin following an open inguinal hernia repair that is interfering with his ability to complete ADLs. He has had poor control of his pain despite multiple medication trials and PT. Due to persistent, debilitating pain, a trial of ilioinguinal or iliohypograstric nerve block is scheduled to relieve pain and improve function.
64430	A 48-year-old female has a two-year history of pudendal neuralgia that is interfering with her ability to complete ADLs. She has poor control of her pain despite multiple medication trials and PT. Due to her persistent, debilitating pain, a trial of pudendal nerve block is scheduled to relieve her pain and improve her function.

FACILITY DIRECT PE INPUTS **CPT CODE(S): 64400, 64405, 64408, 64420, 64425, 64430, 64435, 64449, 64450, 64451, 64454, ___**
SPECIALTY SOCIETY(IES):__AAN, AAPM, AAPM&R, APMA, ASA, NANS, SIS_____
PRESENTER(S):__Richard Rosenquist, MD; Gordon Morewood, MD; Gregory Poston, MD; Wesley Ibazebo, MD; Carlo Milani, MD; Damean Freas, DO; Brooke Bisbee, DPM_____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

64435	A 34-year-old female with an intrauterine device (IUD) presented for IUD removal. The IUD string was not identified on examination, and initial probing of the cervical canal was not tolerated by the patient. Cervical dilation under cervical anesthesia is required for retrieval.
64449	A 62-year-old female undergoes a left total knee replacement (code 27447) under general anesthesia. The surgeon requests a block with a continuous infusion to manage postoperative pain and facilitate rehabilitation. In order to provide postoperative pain control and increased mobility in her knee, a continuous lumbar plexus block is performed.
64450	A 52-year-old female complains of chronic burning pain and a tingling sensation in the plantar aspect of her right foot. Clinical examination is consistent with tarsal tunnel syndrome. The decision is made to perform a therapeutic injection about the posterior tibial nerve utilizing local anesthetic and a steroid.
64451	A 68-year-old male has a five-year history of persistent right sacroiliac pain that is interfering with his ability to complete ADLs. He has had poor control of his pain despite multiple medication trials and PT. Due to his persistent, debilitating pain, a trial of diagnostic nerve blocks to the sacroiliac joint is scheduled to relieve his pain and improve his function.
64454	A 72-year-old female has a five-year history of persistent right knee pain that is interfering with her ability to complete ADLs. She has had poor control of her pain despite multiple medication trials and PT. Due to her persistent, debilitating pain, a trial of genicular nerve blocks is schedule to relieve her pain and improve her function.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
   Our expert panel consisted of advisors from specialties presenting this tab. The specialty societies reviewed current PE inputs for the codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):
   Existing codes were used as reference codes.

3. Is this code(s) typically reported with an E/M service?
   Codes 64435 and 64455 are reported with an E/M service more than 50% of the time.

4. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:
   N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require either minimal or extensive use of clinical staff and

has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

5. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

N/A

6. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

8. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Codes 64400, 64408, 64420, 64425, 64430, 64435, 64449, 64450, 64451 and 64454 have pre-service time in the facility setting. In the facility, this includes coordinating pre-surgery services as well as scheduling space and necessary equipment. Additionally, during this time, staff explains where to come for the appointment, checks medications, runs through list of medical conditions, makes sure the patient is off anti-coagulation drugs, confirms if patient uses BP medications, walks the patient through the procedure, confirms whether a driver is available for a ride home and answers patient questions. For several codes, there is also time required to confirm availability of prior images or studies.

   b. Service period (includes pre, intra and post):

   c. Post-service period:

Codes 64400, 64408, 64420, 64425, 64430, 64435, 64449, 64450, and 64454 have post service time in the facility setting. This includes three minutes time for conducting patient communications following the service.

9. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):

N/A

10. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

11. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

12. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

13. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:
    N/A

14. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
    Several codes use established supply packs.

15. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
    Not used in the facility setting for these codes.

16. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:
    N/A

17. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):
    N/A

18. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?
    No

19. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time)*. If you have selected "other formula" for any of the equipment please explain here:
    Equipment not used in the facility setting for these codes.

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

20. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

21. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition to those revisions, please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_64400, 64405, 64408, 64418, 64420, 64421, 64425, 64430, 64435, 64450, 64451, 64454, 64455_____**
SPECIALTY SOCIETY(IES):_ AAN, AAPM, AAPM&R, APMA, ASA, NANS, SIS _____
PRESENTER(S):_ Richard Rosenquist, MD; Gordon Morewood, MD; Gregory Poston, MD; Wesley Ibazebo, MD; Carlo Milani, MD; Damean Freas, DO; Brooke Bisbee, DPM _____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular	000
64405	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	000
64408	Injection(s), anesthetic agent(s) and/or steroid; vagus nerve	000
64418	Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	000
64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	000
64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level (List separately in addition to code for primary procedures)	ZZZ
64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	000
64430	Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve	
64435	Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve	000
64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	000
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	000
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed	000
64455	Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)	000

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
64400	A patient with a normal neurologic examination reports of headaches that include pain in one or more branches of the trigeminal nerve (ophthalmic, maxillary, or mandibular). An injection of local anesthetic with or without steroid is performed for nerve blockade.
64405	A patient with frequent headaches and a normal neurological examination has tenderness over the left occipital notch, where palpation triggers pain. For both diagnostic and therapeutic purposes, an injection of local anesthetic and anti-inflammatory is recommended.
64408	A 55-year-old female presents with a neurogenic cough. Injection of an anesthetic agent to the vagus nerve is performed.
64418	A 52-year-old woman with a frozen shoulder is unable to tolerate physical therapy due to pain. She is referred for a suprascapular nerve block to provide pain relief so that she can undergo physical therapy.
64420	A 48-year-old female has a two-year history of rib pain that is interfering with her ability to complete ADLs. She has had poor control of her pain despite multiple medication trials and PT. Due to her persistent, debilitating pain, a trial of intercostal nerve block is scheduled to relieve her pain and improve her function.
64421	A 48-year-old female has a two-year history of rib pain that is interfering with her ability to complete ADLs. She has had poor control of her pain despite multiple medication trials and PT. Due to her persistent, debilitating pain, a trial of intercostal nerve blocks involving multiple intercostal spaces is scheduled to relieve her pain and improve her function.

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):_64400, 64405, 64408, 64418, 64420, 64421, 64425, 64430, 64435, 64450, 64451, 64454, 64455_____**
SPECIALTY SOCIETY(IES):_ AAN, AAPM, AAPM&R, APMA, ASA, NANS, SIS _____
PRESENTER(S):_ Richard Rosenquist, MD; Gordon Morewood, MD; Gregory Poston, MD; Wesley Ibazebo, MD; Carlo Milani, MD; Damean Freas, DO; Brooke Bisbee, DPM _____

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

64425	A 48-year-old male has a three-year history of pain in his groin following an open inguinal hernia repair that is interfering with his ability to complete ADLs. He has had poor control of his pain despite multiple medication trials and PT. Due to persistent, debilitating pain, a trial of ilioinguinal or iliohypograstric nerve block is scheduled to relieve pain and improve function.
64430	A 48-year-old female has a two-year history of pudendal neuralgia that is interfering with her ability to complete ADLs. She has poor control of her pain despite multiple medication trials and PT. Due to her persistent, debilitating pain, a trial of pudendal nerve block is scheduled to relieve her pain and improve her function.
64435	A 34-year-old female with an intrauterine device (IUD) presented for IUD removal. The IUD string was not identified on examination, and initial probing of the cervical canal was not tolerated by the patient. Cervical dilation under cervical anesthesia is required for retrieval.
64450	A 52-year-old female complains of chronic burning pain and a tingling sensation in the plantar aspect of her right foot. Clinical examination is consistent with tarsal tunnel syndrome. The decision is made to perform a therapeutic injection about the posterior tibial nerve utilizing local anesthetic and a steroid.
64451	A 68-year-old male has a five-year history of persistent right sacroiliac pain that is interfering with his ability to complete ADLs. He has had poor control of his pain despite multiple medication trials and PT. Due to his persistent, debilitating pain, a trial of diagnostic nerve blocks to the sacroiliac joint is scheduled to relieve his pain and improve his function.
64454	A 72-year-old female has a five-year history of persistent right knee pain that is interfering with her ability to complete ADLs. She has had poor control of her pain despite multiple medication trials and PT. Due to her persistent, debilitating pain, a trial of genicular nerve blocks is schedule to relieve her pain and improve her function.
64455	A 46-year-old female presents with a painful neuroma in the third intermetatarsal space of her right foot. The decision is made to proceed with a therapeutic intermetatarsal neuroma injection.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our expert panel consisted of advisors from specialties presenting this tab. The specialty societies reviewed current PE inputs for the codes.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing codes were used as reference codes.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see the *Billed Together* tab in the RUC Database)

   Codes 64435 and 64455 are reported with an E/M service more than 50% of the time.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see the *Billed Together* tab in the RUC Database)

Non-Facility Dominant Specialties

64400	Neurology (51.9%), Nurse Practitioner (10%), Physicians Assistant (8.1%)
64405	Neurology (45.6%), Pain Management (10.1%), Physical Medicine & Rehabilitation (8.1%)
64408	Otolaryngology (94.4%)
64418	Anesthesiology (19.6%), Pain Management (17.4%), Physical Medicine & Rehabilitation (15.6%)
64420	Physical Medicine & Rehabilitation (22.2%), Pain Management (15.6%), Anesthesiology (14.6%)
64421	Pain Management (22.1%), Interventional Pain Management (19.6%), Anesthesiology (16.3%), Physical Medicine & Rehabilitation (16.3%)
64425	Physical Medicine & Rehabilitation (26.2%), Anesthesiology (14.9%), Pain Management (13.8%)
64430	Obstetcis/Gynecology (37%), Urology (13.2%), Anesthesiology (10.8%)
64435	Obstetrics/Gynecology (77.3%), Anesthesiology (13.6%)
64449	Neurology (29.6%), Interventional Pain Management (24.4%), Family Medicine (18.9%)
64450	Podiatry (17.8%), Family Medicine (16.9%), Nurse Practitioner (14.2%)
64451	No data
64454	No data
64455	Podiatry (93.9%)

Global Dominant Specialties

64400	Neurology (43.4%), Nurse Practitioner (11.8%), Anesthesiology (9.2%)
64405	Neurology (40.4%), Pain Management (11.5%), Anesthesiology (11.4%)
64408	Otolaryngology (94.8%)
64418	Anesthesiology (23.4%), Pain Management (17.9%), Physical Medicine & Rehabilitation (14.4%)
64420	Anesthesiology (43.1%), Pain Management (12.3%), Physical Medicine & Rehabilitation (12.2%)
64421	Anesthesiology (31.6%), Pain Management (20.6%), Interventional Pain Management (18.4%)
64425	Anesthesiology (32.6%), Physical Medicine & Rehabilitation (16.1%), Pain Management (14%)
64430	Obstetrics/Gynecology (24.8%), Anesthesiology (18.5%), Pain Management (13.9%)
64435	Obstetrics/Gynecology (60.5%), Anesthesiology (26.3%)
64449	Anesthesiology (81.9%),
64450	Anesthesiology (31.7%), Podiatry (10.6%), Pain Management (10.5%)
64451	No data

64454	No data
64455	Podiatry (93.3%)

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

Pre-service time is recommended for five codes as noted below in 10.a.

8. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

9. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

Codes in this family primarily include 5 minutes for obtaining vital signs with the exception of code 64408 which has an input of 3 (note this code has a different dominant specialty than all other codes in this tab).

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

Codes 64400, 64420, 64425, 64451, 64454 have pre service time allocated in the non-facility setting. During this time, staff explains where to come for the appointment, checks medications, runs through list of medical conditions, makes sure the patient is off anti-coagulation drugs, confirms if patient uses BP medications, walks the patient through the procedure, confirms whether a driver is

available for a ride home and answers patient questions. For codes 64451 and 64454,, there is also time required to confirm availability of prior images or studies.

b. Service period (includes pre, intra and post):

Codes include time for pre-service of the service period including greeting the patient, providing gowning, ensuring medical records are available, obtaining vital signs, providing education, preparing the room, confirming the order, and set up of the patient. Additionally, time is allotted for assisting the physician with the procedure both for the RN/LPN/MTA and for the radiologic technician for codes 64451 and 64454. Monitoring and cleaning time is also include in post service of the service period.

c. Post-service period:

Most codes in this tab include 3 minutes post-service time for communicating with the patient following the procedure.

11. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

12. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

13. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):

N/A

14. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

Yes – recommending SA041 and SA048 for various codes as listed below in question 19.

19. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

SA041 Pack, basic injection – unit price 4.0507 (codes 64400, 64420, 64425, 64450)

Description	Unit	Item Quantity
paper, exam table	foot	7
gloves, non-sterile	pair	2
gown, patient	item	1
pillow case	item	1
cover, thermometer probe	item	1

SA048 Pack, minimum multi-specialty visit – unit price 11.365 (codes 64400, 64408, 64420, 64425, 64430, 64435, 64450)

Description	Unit	Item Quantity
applicator, sponge-tipped	item	3
bandage, strip 0.75in x 3in	item	1
cap, surgical	item	1
drape, sterile barrier 16in x 29in	item	1
drape, sterile, for Mayo stand	item	1
gauze, sterile 4in x 4in	item	2
gloves, sterile	pair	2
gown, staff, impervious	item	1
gown, surgical, sterile	item	1
lidocaine 1%-2% inj (Xylocaine)	ml	5
mask, surgical	item	1
needle, 18-27g	item	2
povidone soln (Betadine)	ml	10
syringe 3ml	item	1
underpad 2ftx3ft (Chux)	item	1

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

22. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No

23. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF023	Table, exam	Default
EF015	Mayo stand	Default
EQ011	ECG, 3-channel (with SP02, NIBP, temp, resp)	Other Formula – this technology is used in several of the codes both during the procedure and during monitoring time.
EF008	Chair with headrest, exam, reclining	Default
EQ168	Light, exam	Default
EF031	Table, power	Default
EL018	Room, mobile c-ARM	Default
ED050	Technologist PACS workstation	PACS
EF027	Table, equipment, mobile	PACS

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)
NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 77002, 77003**

SPECIALTY SOCIETY(IES): ACR, SIR, SIS, AAPM, AAPM&R, ASA

PRESENTER(S): Lauren Golding, MD; Andy Moriarity, MD; Richard Rosenquist, MD; Neal Cohen, MD; Gordon Morewood, MD; Gregory Polston, MD; Wesley Ibazebo, MD; David Reece, DO; Carlo Milani, MD; Curtis Anderson, MD; Minhaj Khaja, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	ZZZ
77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
77002	A 65-year-old male with hip pain and suspected joint effusion is referred for joint aspiration. Fluoroscopic guidance is used to advance a needle into the joint space, and the joint fluid is aspirated (needle aspiration is reported separately).
77003	Fluoroscopic guidance is used for needle placement during a separately reported underlying procedure involving the spine (eg, biopsy, aspiration, injection).

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The American College of Radiology, Society of Interventional Radiology, Spine Intervention Society, American Academy of Pain Medicine, American Academy of Physical Medicine & Rehabilitation, and American Society of Anesthesiologists convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for two fluoroscopic guidance codes related to needle placement and localization of needle or catheter tip.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   For our reference codes, the societies are providing the current inputs for CPT codes 77002 and 77003.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see the *Billed Together* tab in the RUC Database)

77002
CPT code 77002 is typically reported with an E/M service at 15.2%.
CPT code 77002 is typically reported with an E/M service in the non-facility at 20.9%.

77003
CPT code 77003 is typically reported with an E/M service at 2.2%.
CPT code 77003 is typically reported with an E/M service in the non-facility at 14.5%.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see the *Billed Together* tab in the RUC Database)

77002
According to the RUC database in the non-facility (Global & 26), Physical Medicine and Rehabilitation is the dominant specialty at 16%. Diagnostic Radiology is the dominant specialty for the global (all sites) at 23%.

77003
According to the RUC database in the non-facility (Global & 26), Diagnostic Radiology is the dominant specialty at 26.3%. Diagnostic Radiology is also the dominant specialty for the global (all sites) at 68.2%.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

The specialties believe that the existing PE clinical staff and supply inputs for CPT codes 77002 and 77003 are appropriate and remain accurate. The increase over the aggregate current cost is due to the addition of the Professional PACS workstation (ED053). We believe the omission of the Professional PACS workstation from previous review was an oversight, and we have included the appropriate minutes in the PE spreadsheet.

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

We are recommending to maintain 2 minutes for *Review patient clinical extant information and questionnaire* (CA007) for both 77002 and 77003 when the RUC standard is 1 minute. Two minutes is required for discussing radiation safety, risk of pregnancy and contrast allergy/renal insufficiency prior to any fluoroscopic guided procedure.

8. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A.

9. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A.

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

77002 & 77003 The clinical staff will ensure that copies of imaging and imaging reports are available for physician review prior to the procedure. In addition, the staff will discuss possibility of patient being pregnant with the patient and offer POC pregnancy test, if necessary. In addition, any prior contrast allergic reactions will be discussed with patient.

    b. Service period (includes pre, intra and post):

77002 & 77003 The clinical staff will ensure that all equipment is available for procedure and will position table and equipment appropriately for procedure. Subsequently, the patient will be brought to the room and positioned appropriately on the table. IV will be started as needed. During the procedure, the radiologic technologist will assist in the imaging portion of the procedure. After completion of the procedure the staff will clean the table and imaging equipment and ensure transfer of images to PACS as well as transfer of any requisition or other paperwork into PACS. Clinical staff will confirm the adequacy of images and data with the physician.

    c. Post-service period:

N/A.

11. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

77002 & 77003
The clinical staff time is 100% linked to the physician work time for the imaging guided portion of the procedure. The staff member is operating imaging equipment, storing images, and acting as a non-sterile circulating staff member in the room.

12. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A.

13. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):
N/A.

14. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
N/A.

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:
N/A.

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
N/A.

19. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
N/A.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A.

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A.

22. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A.

23. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

- **Technologist PACS workstation (ED050)** = PACS formula
- **Professional PACS workstation (ED053) =** Sum of half of physician pre-time and full physician intra-service time
- **Room, radiographic-fluoroscopic (EL014)** = Highly technical formula

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

N/A.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 76942**
SPECIALTY SOCIETY(IES): ACR, SIR, SIS, AAPM&R
PRESENTER(S): Lauren Golding, MD; Andy Moriarity, MD; David Reece, DO; Carlo Milani, MD; Wesley Ibazebo, MD; Curtis Anderson, MD; Minhaj Khaja, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
76942	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
76942	Ultrasonic guidance is utilized for needle placement during a separately reported underlying procedure (eg, biopsy, aspiration, injection).

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The American College of Radiology, Society of Interventional Radiology, Spine Intervention Society, and American Academy of Physical Medicine & Rehabilitation convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for ultrasonic guidance for needle placement.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   For our reference code, the societies are providing the current inputs for CPT code 76942.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see the *Billed Together* tab in the RUC Database)

   CPT code 76942 is typically reported with an E/M service at 17.3%.
   CPT code 76942 is typically reported with an E/M service in the non-facility at 45.5%.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see the *Billed Together* tab in the RUC Database)

   According to the RUC database in the non-facility (Global & 26), Urology is the dominant specialty at 12.6%. Anesthesiology is the dominant specialty for the global (all sites) at 44.4%.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

The specialties believe that the existing PE clinical staff, supply, and equipment inputs for CPT code 76942 are appropriate and remain accurate. The proposed increase over the aggregate current cost is simply due to the updated calculation of equipment time for the Technologist PACS workstation (ED050). In October 2017, CMS previously assigned 15 minutes for the Technologist PACS workstation for CPT code 76942. However, the societies have updated these minutes based on the PACS formula, thus resulting in 27 minutes for ED050, which the societies believe to be appropriate.

CLINICAL STAFF ACTIVITIES

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No.

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

N/A.

8. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A.

9. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A.

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

The clinical staff will ensure that copies of imaging and imaging reports are available for physician review prior to the procedure.

    b. Service period (includes pre, intra and post):

The clinical staff will ensure that all equipment is available for procedure and will position table and equipment appropriately for procedure. Subsequently, the patient will be brought to the room and positioned appropriately on the table. IV will be started as needed. During the procedure, the clinical staff will assist in the imaging portion of the procedure by adjusting ultrasound imaging parameters under physician direction. After completion of the procedure, the staff will clean the table and imaging equipment, and ensure transfer of images to PACS as well as transfer of any requisition or other paperwork into PACS. Clinical staff will confirm the adequacy of images and data with the physician.

    c. Post-service period:

N/A.

11. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly*

related to physician work time or *Perform procedure/service---NOT directly related to physician work time:*

During the intra-service period, the clinical staff assists the physician in the procedure as a circulator, adjusts and operates the ultrasound equipment, monitors and tends to the patient and works with any additional scrubbed in staff (depending on the base procedure) in hand off of biopsy samples or other non-sterile aspects of the procedure.

12. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A.

13. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):

N/A.

14. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A.

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A.

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A.

19. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A.

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A.

22. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A.

23. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

- **Technologist PACS workstation (ED050)** = PACS formula
- **Professional PACS workstation (ED053)** = Sum of half of pre-service physician time and full intra-service physician time
- **Ultrasound unit, portable (EQ250)** = Highly technical formula

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

N/A.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

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NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 76942**

SPECIALTY SOCIETY(IES): ACR, SIR, SIS, AAPM&R

PRESENTER(S): Lauren Golding, MD; Andy Moriarity, MD; David Reece, DO; Carlo Milani, MD; Wesley Ibazebo, MD; Curtis Anderson, MD; Minhaj Khaja, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**	
2						**76942**		**64415**		**64415**	
3		***RUC Collaboration Website***				Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device),		Injection(s), anesthetic agent(s) and/or steroid; brachial plexus		Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed	
4	**Clinical Activity Code**	**Meeting Date:** October 2021 **Revision Date (if applicable):** **Tab:** 5 **Specialty:** ASA and ASIPP	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**				
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 20.87**	**$ -**	**$ 55.63**	**$ 4.44**	**$ 71.32**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**29.0**	**0.0**	**46.0**	**12.0**	**58.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**2.0**	**0.0**	**3.0**	**9.0**	**5.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**27.0**	**0.0**	**40.0**	**0.0**	**50.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 10.73**	**$ -**	**$ 17.02**	**$ 4.44**	**$ 21.46**	**$ 4.44**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37						
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37				3		3
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37				3		3
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37						
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37			3	3	3	3
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37	2				2	
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37						
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37						
23			L037D	RN/LPN/MTA	0.37						
26		*Other activity: please include short clinical description here and type*	L037D	RN/LPN/MTA	0.37						
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.37			3		3	
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37			5		5	
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37			2		2	
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37						
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	2				2	
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37						
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37						
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37	2				2	
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37						
42			L037D	RN/LPN/MTA	0.37						
45		*Other activity: please include short clinical description here and type*	L037D	RN/LPN/MTA	0.37						
48		**Intra-service (of service period)**									
49	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37			12		10	
50	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
51	CA020	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37	15					
55			L037D	RN/LPN/MTA	0.37						
56		*Other activity: please include short clinical description here and type*	L037D	RN/LPN/MTA	0.37						
59		**Post-Service (of service period)**									
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37			15		15	
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37						
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	3				3	
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37						
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37						
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37						
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37						
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37			1		1	
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L037D	RN/LPN/MTA	0.37	2				2	
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37	2				2	
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L037D	RN/LPN/MTA	0.37	1				1	
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37						
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	L037D	RN/LPN/MTA	0.37						
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37			2		2	
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**	
75			L037D	RN/LPN/MTA	0.37						
78		*Other activity: please include short clinical description here and type*	L037D	RN/LPN/MTA	0.37						
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37			3	3	3	3
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37						
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16								
88		99212 27 minutes	27								
89		99213 36 minutes	36								
90		99214 53 minutes	53								
91		99215 63 minutes	63								
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37						
96		*Other activity: please include short clinical description here and type*	L037D	RN/LPN/MTA	0.37						
99		**End: with last office visit before end of global period**									

	A	B	D	E	F	G	H	I	J	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**	
2						**76942**		**64415**		**64415**	
3		***RUC Collaboration Website***				Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device),		Injection(s), anesthetic agent(s) and/or steroid; brachial plexus		Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed	
4	**Clinical Activity Code**	**Meeting Date:** October 2021 **Revision Date (if applicable):** **Tab:** 5 **Specialty:** ASA and ASIPP	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**				
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 20.87**	**$ -**	**$ 55.63**	**$ 4.44**	**$ 71.32**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**29.0**	**0.0**	**46.0**	**12.0**	**58.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**2.0**	**0.0**	**3.0**	**9.0**	**5.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**27.0**	**0.0**	**40.0**	**0.0**	**50.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 6.21**	**$ -**	**$ 37.47**	**$ -**	**$ 43.68**	**$ -**
102	SA041	pack, basic injection	10.755	pack				1		1	
103	SA048	pack, minimum multi-specialty visit	4.0507	pack				1		1	
104	SB005	cover-condom, transducer or ultrasound probe	3.4325	item		1				1	
105	SC051	syringe 10-12ml	0.2035	item							
106	SC053	syringe 20ml	0.762	item				2		2	
107	SD050	electrode needle, injectable (Myoject)	23.8175	item							
108	SG056	gauze, sterile 4in x 4in (10 pack uou)	1.0995	item				2		2	
109	SH022	bupivacaine 0.5% inj (Marcaine)	0.13	ml				30		30	
110	SH023	chlorhexidine 0.12% (Peridex)	0.627	oz				1		1	
111	SH047	lidocaine 1%-2% inj (Xylocaine)	0.0537	ml				5		5	
112	SJ033	lubricating jelly (Surgilube)	0.5527	oz		4				4	
113	SK075	skin marking pen, sterile (Skin Skribe)	1.477	item				1		1	
114	SM012	disinfectant spray (Transeptic)	0.0445	ml		10				10	
115	SM021	sanitizing cloth-wipe (patient)	0.0617	item		2				2	
116	SC038	needle, epidural (RK)	10.975	item				1		1	
117	SB019	drape-towel, sterile 18in x 26in	0.423	item				4		4	
118	SH021	bupivacaine 0.25% inj (Marcaine)	0.4385	ml							
119		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
121	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
122		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 3.93**	**$ -**	**$ 1.15**	**$ -**	**$ 6.18**	**$ -**
123	EQ184	nerve stimulator (eg, for nerve block)	572.3	Default	0.001847174						
124	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	3434.875	Other	0.011086513			83		88	
125	EQ250	ultrasound unit, portable	38709.1497	Default	0.150002878	24				28	
126	ED050	Technologist PACS workstation	5557	PACS	0.022017924	15				33	
127	EF023	table, exam	3887.8377	Default	0.008648083			23		28	
128	EF015	mayo stand	524.793	Default	0.001167346			23		28	
129											
130		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	M	N	O	P	Q	R	S	T	U	V
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**	
2			**64417**		**64417**		**64445**		**64445**		**64447**	
3		***RUC Collaboration Website***	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve		Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed		Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve		Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed		Injection(s), anesthetic agent(s) and/or steroid; femoral nerve	
4	**Clinical Activity Code**	**Meeting Date:** October 2021 **Revision Date (if applicable):** **Tab:** 5 **Specialty:** ASA and ASIPP										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**					**000**	**000**	**000**	**000**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 81.58**	**$ 4.44**	**$ 98.04**	**$ 4.44**	**$ 67.38**	**$ 4.44**	**$ 81.05**	**$ 4.44**	**$ 40.83**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	**44.0**	**12.0**	**58.0**	**12.0**	**51.0**	**12.0**	**58.0**	**12.0**	**40.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**3.0**	**9.0**	**5.0**	**9.0**	**3.0**	**9.0**	**5.0**	**9.0**	**3.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**38.0**	**0.0**	**50.0**	**0.0**	**45.0**	**0.0**	**50.0**	**0.0**	**34.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 16.28**	**$ 4.44**	**$ 21.46**	**$ 4.44**	**$ 18.87**	**$ 4.44**	**$ 21.46**	**$ 4.44**	**$ 14.80**	**$ 4.44**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001	Complete pre-service diagnostic and referral forms										
16	CA002	Coordinate pre-surgery services (including test results)		3		3		3		3		3
17	CA003	Schedule space and equipment in facility		3		3		3		3		3
18	CA004	Provide pre-service education/obtain consent										
19	CA005	Complete pre-procedure phone calls and prescription	3	3	3	3	3	3	3	3	3	3
20	CA006	Confirm availability of prior images/studies			2				2			
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)										
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	3		3		3		3		3	
34	CA010	Obtain vital signs	5		5		5		5		5	
35	CA011	Provide education/obtain consent	2		2		2		2		2	
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies			2		2		2			
38	CA014	Confirm order, protocol exam										
39	CA015	Setup scope (nonfacility setting only)										
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient			2		2		2			
41	CA017	Sedate/apply anesthesia										
42												
45		*Other activity: please include short clinical description here and type*										
48		**Intra-service (of service period)**										
49	CA018	Assist physician or other qualified healthcare professional---directly	10		10		10		10		6	
50	CA019	Assist physician or other qualified healthcare professional---directly										
51	CA020	Assist physician or other qualified healthcare professional---directly										
52	CA021	Perform procedure/service---NOT directly related to physician work time										
55												
56		*Other activity: please include short clinical description here and type*										
59		**Post-Service (of service period)**										
60	CA022	Monitor patient following procedure/service, multitasking 1:4	15		15		15		15		15	
61	CA023	Monitor patient following procedure/service, no multitasking										
62	CA024	Clean room/equipment by clinical staff			3		3		3			
63	CA025	Clean scope										
64	CA026	Clean surgical instrument package										
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
66	CA028	Review/read post-procedure x-ray, lab and pathology reports										
67	CA029	Check dressings, catheters, wounds	1		1		1		1		1	
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,			2				2			
69	CA031	Review examination with interpreting MD/DO			2				2			
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to			1				1			
71	CA033	Perform regulatory mandated quality assurance activity (service period)										
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry										
73	CA035	Review home care instructions, coordinate visits/prescriptions	2		2		2		2		2	
74	CA036	Discharge day management	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
75												
78		*Other activity: please include short clinical description here and type*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037	Conduct patient communications	3	3	3	3	3	3	3	3	3	3
85	CA038	Coordinate post-procedure services										
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93												
96		*Other activity: please include short clinical description here and type*										
99		**End: with last office visit before end of global period**										

	A	B	M	N	O	P	Q	R	S	T	U	V
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**	
2			**64417**		**64417**		**64445**		**64445**		**64447**	
3		***RUC Collaboration Website***	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve		Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed		Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve		Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed		Injection(s), anesthetic agent(s) and/or steroid; femoral nerve	
4	**Clinical Activity Code**	**Meeting Date:** October 2021 **Revision Date (if applicable):** **Tab:** 5 **Specialty:** ASA and ASIPP										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**					**000**	**000**	**000**	**000**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 81.58**	**$ 4.44**	**$ 98.04**	**$ 4.44**	**$ 67.38**	**$ 4.44**	**$ 81.05**	**$ 4.44**	**$ 40.83**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	**44.0**	**12.0**	**58.0**	**12.0**	**51.0**	**12.0**	**58.0**	**12.0**	**40.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**3.0**	**9.0**	**5.0**	**9.0**	**3.0**	**9.0**	**5.0**	**9.0**	**3.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**38.0**	**0.0**	**50.0**	**0.0**	**45.0**	**0.0**	**50.0**	**0.0**	**34.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
100	**Supply Code**	**MEDICAL SUPPLIES**										
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 64.20**	**$ -**	**$ 70.41**	**$ -**	**$ 47.21**	**$ -**	**$ 53.42**	**$ -**	**$ 25.00**	**$ -**
102	SA041	pack, basic injection	1		1		1		1		1	
103	SA048	pack, minimum multi-specialty visit	1		1		1		1		1	
104	SB005	cover-condom, transducer or ultrasound probe			1				1			
105	SC051	syringe 10-12ml									1	
106	SC053	syringe 20ml	2		2		2		2		2	
107	SD050	electrode needle, injectable (Myoject)	1		1		1		1			
108	SG056	gauze, sterile 4in x 4in (10 pack uou)	2		2		2		2		2	
109	SH022	bupivacaine 0.5% inj (Marcaine)					15		15		30	
110	SH023	chlorhexidine 0.12% (Peridex)	1		1		1		1		1	
111	SH047	lidocaine 1%-2% inj (Xylocaine)					15		15		5	
112	SJ033	lubricating jelly (Surgilube)			4				4			
113	SK075	skin marking pen, sterile (Skin Skribe)	1		1		1		1		1	
114	SM012	disinfectant spray (Transeptic)			10				10			
115	SM021	sanitizing cloth-wipe (patient)			2				2			
116	SC038	needle, epidural (RK)	1		1							
117	SB019	drape-towel, sterile 18in x 26in										
118	SH021	bupivacaine 0.25% inj (Marcaine)	20		20							
119		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
121	**Equipment Code**	**EQUIPMENT**										
122		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 1.10**	**$ -**	**$ 6.18**	**$ -**	**$ 1.30**	**$ -**	**$ 6.18**	**$ -**	**$ 1.02**	**$ -**
123	EQ184	nerve stimulator (eg, for nerve block)					28		0			
124	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	81		88		88		88		77	
125	EQ250	ultrasound unit, portable			28				28			
126	ED050	Technologist PACS workstation			33				33			
127	EF023	table, exam	21		28		28		28		17	
128	EF015	mayo stand	21		28		28		28		17	
129												
130		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**	
2			**64447**	
3		***RUC Collaboration Website***	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed	
4	**Clinical Activity Code**	**Meeting Date:** October 2021 **Revision Date (if applicable):** **Tab:** 5 **Specialty:** ASA and ASIPP		
5		**LOCATION**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 57.73**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	**56.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**5.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**48.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 20.72**	**$ 4.44**
13		**PRE-SERVICE PERIOD**		
14		**Start: Following visit when decision for surgery/procedure made**		
15	CA001	Complete pre-service diagnostic and referral forms		
16	CA002	Coordinate pre-surgery services (including test results)		3
17	CA003	Schedule space and equipment in facility		3
18	CA004	Provide pre-service education/obtain consent		
19	CA005	Complete pre-procedure phone calls and prescription	3	3
20	CA006	Confirm availability of prior images/studies	2	
21	CA007	Review patient clinical extant information and questionnaire		
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)		
23				
26		*Other activity: please include short clinical description here and type*		
29		**End: When patient enters office/facility for surgery/procedure**		
30		**SERVICE PERIOD**		
31		**Start: When patient enters office/facility for surgery/procedure:**		
32		**Pre-Service (of service period)**		
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	3	
34	CA010	Obtain vital signs	5	
35	CA011	Provide education/obtain consent	2	
36	CA012	Review requisition, assess for special needs		
37	CA013	Prepare room, equipment and supplies	2	
38	CA014	Confirm order, protocol exam		
39	CA015	Setup scope (nonfacility setting only)		
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2	
41	CA017	Sedate/apply anesthesia		
42				
45		*Other activity: please include short clinical description here and type*		
48		**Intra-service (of service period)**		
49	CA018	Assist physician or other qualified healthcare professional---directly	8	
50	CA019	Assist physician or other qualified healthcare professional---directly		
51	CA020	Assist physician or other qualified healthcare professional---directly		
52	CA021	Perform procedure/service---NOT directly related to physician work time		
55				
56		*Other activity: please include short clinical description here and type*		
59		**Post-Service (of service period)**		
60	CA022	Monitor patient following procedure/service, multitasking 1:4	15	
61	CA023	Monitor patient following procedure/service, no multitasking		
62	CA024	Clean room/equipment by clinical staff	3	
63	CA025	Clean scope		
64	CA026	Clean surgical instrument package		
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions		
66	CA028	Review/read post-procedure x-ray, lab and pathology reports		
67	CA029	Check dressings, catheters, wounds	1	
68	CA030	Technologist QC's images in PACS, checking for all images, reformats,	2	
69	CA031	Review examination with interpreting MD/DO	2	
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to	1	
71	CA033	Perform regulatory mandated quality assurance activity (service period)		
72	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry		
73	CA035	Review home care instructions, coordinate visits/prescriptions	2	
74	CA036	Discharge day management	**n/a**	
75				
78		*Other activity: please include short clinical description here and type*		
81		**End: Patient leaves office/facility**		
82		**POST-SERVICE PERIOD**		
83		**Start: Patient leaves office/facility**		
84	CA037	Conduct patient communications	3	3
85	CA038	Coordinate post-procedure services		
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**
87		99211 16 minutes		
88		99212 27 minutes		
89		99213 36 minutes		
90		99214 53 minutes		
91		99215 63 minutes		
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**
93				
96		*Other activity: please include short clinical description here and type*		
99		**End: with last office visit before end of global period**		

	A	B	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**	
2			**64447**	
3		***RUC Collaboration Website***	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed	
4	**Clinical Activity Code**	**Meeting Date:** October 2021 **Revision Date (if applicable):** **Tab:** 5 **Specialty:** ASA and ASIPP		
5		**LOCATION**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 57.73**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	**56.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**5.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**48.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**
100	**Supply Code**	**MEDICAL SUPPLIES**		
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 31.22**	**$ -**
102	SA041	pack, basic injection	1	
103	SA048	pack, minimum multi-specialty visit	1	
104	SB005	cover-condom, transducer or ultrasound probe	1	
105	SC051	syringe 10-12ml	1	
106	SC053	syringe 20ml	2	
107	SD050	electrode needle, injectable (Myoject)		
108	SG056	gauze, sterile 4in x 4in (10 pack uou)	2	
109	SH022	bupivacaine 0.5% inj (Marcaine)	30	
110	SH023	chlorhexidine 0.12% (Peridex)	1	
111	SH047	lidocaine 1%-2% inj (Xylocaine)	5	
112	SJ033	lubricating jelly (Surgilube)	4	
113	SK075	skin marking pen, sterile (Skin Skribe)	1	
114	SM012	disinfectant spray (Transeptic)	10	
115	SM021	sanitizing cloth-wipe (patient)	2	
116	SC038	needle, epidural (RK)		
117	SB019	drape-towel, sterile 18in x 26in		
118	SH021	bupivacaine 0.25% inj (Marcaine)		
119		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*		
121	**Equipment Code**	**EQUIPMENT**		
122		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 5.79**	**$ -**
123	EQ184	nerve stimulator (eg, for nerve block)		
124	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	86	
125	EQ250	ultrasound unit, portable	26	
126	ED050	Technologist PACS workstation	31	
127	EF023	table, exam	26	
128	EF015	mayo stand	26	
129				
130		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*		

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED (Affirmation of Oct 2018 inputs)**		**CURRENT**	
2						**64400**		**64400**		**64405**	
3		***RUC Collaboration Website***				Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie,		Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie,		Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 42.44**	**$ 4.44**	**$ 42.44**	**$ 4.44**	**$ 13.11**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**32.0**	**12.0**	**32.0**	**12.0**	**18.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**9.0**	**3.0**	**9.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**26.0**	**0.0**	**26.0**	**0.0**	**18.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 11.84**	**$ 4.44**	**$ 11.84**	**$ 4.44**	**$ 6.66**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37						
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37		3		3		
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		3		3		
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37						
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	3	3	3	3		
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37						
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37						
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37						
23			L037D	RN/LPN/MTA	0.37						
26		*Other activity: please include short clinical description here and type*	L037D	RN/LPN/MTA	0.37						
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.37	3		3			
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	5		5			
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37	2		2		3	
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37						
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	2		2		2	
38	CA013	Prepare room, equipment and supplies	L041B	Radiologic	0.41						
39	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37						
40	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37						
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37	2		2		2	
42	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37						
43			L037D	RN/LPN/MTA	0.37						
46		*Other activity: please include short clinical description here and type*	L037D	RN/LPN/MTA	0.37						
49		**Intra-service (of service period)**									
50	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37	6		6		5	
51	CA018	Assist physician or other qualified healthcare professional---directly	L041B	Radiologic	0.41						
52	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
53	CA020	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37						
54	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37						
57			L037D	RN/LPN/MTA	0.37						
58		*Other activity: please include short clinical description here and type*	L037D	RN/LPN/MTA	0.37						
61		**Post-Service (of service period)**									
62	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37						
63	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37					3	
64	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	3		3			
65	CA025	Clean scope	L037D	RN/LPN/MTA	0.37						
66	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37						
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37						
68	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37						
69	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37	1		1		1	
70	CA030	Technologist QC's images in PACS, checking for all images, reformats,	L041B	Radiologic	0.41						
71	CA031	Review examination with interpreting MD/DO	L041B	Radiologic	0.41						
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to	L041B	Radiologic	0.41						
73	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37						
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	L037D	RN/LPN/MTA	0.37						
75	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37	2		2		2	
76	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**	
77			L037D	RN/LPN/MTA	0.37						
80		*Other activity: please include short clinical description here and type*	L037D	RN/LPN/MTA	0.37						
83		**End: Patient leaves office/facility**									
84		**POST-SERVICE PERIOD**									
85		**Start: Patient leaves office/facility**									
86	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37	3	3	3	3		
87	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37						
88		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes	16								
90		99212 27 minutes	27								
91		99213 36 minutes	36								
92		99214 53 minutes	53								
93		99215 63 minutes	63								
94	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
95			L037D	RN/LPN/MTA	0.37						
98		*Other activity: please include short clinical description here and type*	L037D	RN/LPN/MTA	0.37						
101		**End: with last office visit before end of global period**									

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED (Affirmation of Oct 2018 inputs)**		**CURRENT**	
2						**64400**		**64400**		**64405**	
3		***RUC Collaboration Website***				Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie,		Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie,		Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve	
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 42.44**	**$ 4.44**	**$ 42.44**	**$ 4.44**	**$ 13.11**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**32.0**	**12.0**	**32.0**	**12.0**	**18.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**9.0**	**3.0**	**9.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**26.0**	**0.0**	**26.0**	**0.0**	**18.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**
102	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 30.36**	**$ -**	**$ 30.36**	**$ -**	**$ 6.31**	**$ -**
104	SA041	pack, basic injection	10.755	pack		1		1			
105	SA048	pack, minimum multi-specialty visit	4.0507	pack		1		1			
106	SC028	needle, 18-26g 1.5-3.5in, spinal	8.2985	item		1		1			
107	SK075	skin marking pen, sterile (Skin Skribe)	1.477	item		1		1			
108	SH021	bupivacaine 0.25% inj (Marcaine)	0.4385	ml		5		5		5	
109	SH023	chlorhexidine 0.12% (Peridex)	0.627	oz		1		1			
110	SG056	gauze, sterile 4in x 4in (10 pack uou)	1.0995	item		2		2			
111	SC053	syringe 20ml	0.762	item		1		1			
112	SB024	gloves, sterile	0.8925	pair						1	
113	SG055	gauze, sterile 4in x 4in	0.1823	item						1	
114	SC029	needle, 18-27g	0.0523	item						2	
115	SC051	syringe 10-12ml	0.2035	item						1	
116	SG009	applicator, sponge-tipped	0.1472	item						1	
117	SJ041	povidone soln (Betadine)	0.2587	ml						10	
118	SC034	needle, blunt tip	0.585	item							
119	SJ053	swab-pad, alcohol	0.0333	item							
120	SH047	lidocaine 1%-2% inj (Xylocaine)	0.0537	ml							
121	SH022	bupivacaine 0.5% inj (Marcaine)	0.13	ml							
122	SG021	bandage, strip 0.75in x 3in (Bandaid)	0.3182	item							
123	SC057	syringe 5-6ml	0.135	item							
124	SC038	needle, epidural (RK)	10.975	item							
125	SA051	pack, pelvic exam	15.413	pack							
126	SB006	drape, non-sterile, sheet 40in x 60in	0.153	item							
127	SJ052	swab, procto 16in	0.2318	item							
128	SJ043	povidone swabsticks (3 pack uou)	0.4622	item							
129	SA129	pudendal block tray, sterile	5.24	item							
130	SB001	cap, surgical	0.9072	item							
131	SB033	mask, surgical	0.43	item							
132	SB007	drape, sterile barrier 16in x 29in	0.506	item							
133	SB012	drape, sterile, for Mayo stand	1.2245	item							
134	SJ081	swab, patient prep, 1.5 ml (chloraprep)	1.0775	item							
135	SJ001	alcohol isopropyl 70%	0.023	ml							
136	SB028	gown, surgical, sterile	5.0152	item							
137	SB027	gown, staff, impervious	1.186	item							
138	SB022	gloves, non-sterile	0.246	pair							
139	SB026	gown, patient	0.5757	item							
140	SB004	cover, thermometer probe	0.1745	item							
141	SB036	paper, exam table	0.014	foot							
142	SB044	underpad 2ft x 3ft (Chux)	0.2975	item							
143	SB037	pillow case	0.4293	item							
144	SB019	drape-towel, sterile 18in x 26in	0.423	item							
145	SB008	drape, sterile, c-arm, fluoro	5.161	item							
146	SD269	Grounding pad	2.2575	item							
147	SD087	guide, needle, for localization	18.655	item							
148	SL259	Bleach cleaning wipe	0.5525	item							
149											
150											
151		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
153	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
154		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 0.24**	**$ -**	**$ 0.24**	**$ -**	**$ 0.14**	**$ -**
155	EF023	table, exam	3887.8377	Default	0.008648083	24		24		16	
156	EF015	mayo stand	524.793	Default	0.001167346	24		24			
157	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	3434.875	Other	0.011086513						
158	EF008	chair with headrest, exam, reclining	5565.6015	Default	0.01238009						
159	EQ168	light, exam	1332.1952	Default	0.003535282						
160	EF031	table, power	5968.4775	Default	0.015838707						
161	EL018	room, mobile c-ARM	151200	Default	0.572899695						
162	ED050	Technologist PACS workstation	5557	PACS	0.022017924						
163	EF027	table, instrument, mobile	557.4445	PACS	0.001239976						
164											
165		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	O	P	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED (Affirmation of April 2017 inputs)**		**CURRENT**		**RECOMMENDED (Affirmation of Oct 2018 inputs)**		**CURRENT**		**RECOMMENDED (Affirmation of April 2016 Inputs)**	
2			**64405**		**64408**		**64408**		**64418**		**64418**	
3		***RUC Collaboration Website***	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve		Injection(s), anesthetic agent(s) and/or steroid; vagus nerve		Injection(s), anesthetic agent(s) and/or steroid; vagus nerve		Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve		Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	
4	**Clinical Activity Code**	**Meeting Date: October 2021** **Revision Date (if applicable):** **Tab: 5** **Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 13.11**	**$ -**	**$ 29.94**	**$ 2.96**	**$ 29.94**	**$ 2.96**	**$ 25.03**	**$ -**	**$ 25.03**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**18.0**	**0.0**	**32.0**	**8.0**	**32.0**	**8.0**	**22.0**	**0.0**	**22.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**5.0**	**0.0**	**5.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**18.0**	**0.0**	**29.0**	**0.0**	**29.0**	**0.0**	**22.0**	**0.0**	**22.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 6.66**	**$ -**	**$ 11.84**	**$ 2.96**	**$ 11.84**	**$ 2.96**	**$ 8.14**	**$ -**	**$ 8.14**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001	Complete pre-service diagnostic and referral forms										
16	CA002	Coordinate pre-surgery services (including test results)										
17	CA003	Schedule space and equipment in facility				5		5				
18	CA004	Provide pre-service education/obtain consent										
19	CA005	Complete pre-procedure phone calls and prescription										
20	CA006	Confirm availability of prior images/studies										
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)										
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are			3		3					
34	CA010	Obtain vital signs			3		3					
35	CA011	Provide education/obtain consent	3		2		2		3		3	
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies	2		2		2		2		2	
38	CA013	Prepare room, equipment and supplies										
39	CA014	Confirm order, protocol exam										
40	CA015	Setup scope (nonfacility setting only)										
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2									
42	CA017	Sedate/apply anesthesia										
43												
46		*Other activity: please include short clinical description here and type*										
49		**Intra-service (of service period)**										
50	CA018	Assist physician or other qualified healthcare professional---directly	5		5		5		10		10	
51	CA018	Assist physician or other qualified healthcare professional---directly										
52	CA019	Assist physician or other qualified healthcare professional---directly										
53	CA020	Assist physician or other qualified healthcare professional---directly										
54	CA021	Perform procedure/service---NOT directly related to physician work time										
57												
58		*Other activity: please include short clinical description here and type*										
61		**Post-Service (of service period)**										
62	CA022	Monitor patient following procedure/service, multitasking 1:4			8		8					
63	CA023	Monitor patient following procedure/service, no multitasking	3						3		3	
64	CA024	Clean room/equipment by clinical staff			3		3					
65	CA025	Clean scope										
66	CA026	Clean surgical instrument package										
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
68	CA028	Review/read post-procedure x-ray, lab and pathology reports										
69	CA029	Check dressings, catheters, wounds	1		1		1		2		2	
70	CA030	Technologist QC's images in PACS, checking for all images, reformats,										
71	CA031	Review examination with interpreting MD/DO										
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to										
73	CA033	Perform regulatory mandated quality assurance activity (service period)										
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry										
75	CA035	Review home care instructions, coordinate visits/prescriptions	2		2		2		2		2	
76	CA036	Discharge day management	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
77												
80		*Other activity: please include short clinical description here and type*										
83		**End: Patient leaves office/facility**										
84		**POST-SERVICE PERIOD**										
85		**Start: Patient leaves office/facility**										
86	CA037	Conduct patient communications			3	3	3	3				
87	CA038	Coordinate post-procedure services										
88		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes										
90		99212 27 minutes										
91		99213 36 minutes										
92		99214 53 minutes										
93		99215 63 minutes										
94	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
95												
98		*Other activity: please include short clinical description here and type*										
101		**End: with last office visit before end of global period**										

	A	B	O	P	Q	R	S	T	U	V	W	X
1	RUC Practice Expense Spreadsheet		RECOMMENDED (Affirmation of April 2017 inputs)		CURRENT		RECOMMENDED (Affirmation of Oct 2018 inputs)		CURRENT		RECOMMENDED (Affirmation of April 2016 Inputs)	
2			64405		64408		64408		64418		64418	
3		*RUC Collaboration Website*	Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve		Injection(s), anesthetic agent(s) and/or steroid; vagus nerve		Injection(s), anesthetic agent(s) and/or steroid; vagus nerve		Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve		Injection(s), anesthetic agent(s) and/or steroid; suprascapular nerve	
4	Clinical Activity Code	Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS										
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	000	000	000	000	000	000	000	000	000	000
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 13.11	$ -	$ 29.94	$ 2.96	$ 29.94	$ 2.96	$ 25.03	$ -	$ 25.03	$ -
8		TOTAL CLINICAL STAFF TIME	18.0	0.0	32.0	8.0	32.0	8.0	22.0	0.0	22.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	5.0	0.0	5.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	18.0	0.0	29.0	0.0	29.0	0.0	22.0	0.0	22.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	3.0	3.0	3.0	3.0	0.0	0.0	0.0	0.0
102	Supply Code	MEDICAL SUPPLIES										
103		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ 6.31	$ -	$ 17.85	$ -	$ 17.85	$ -	$ 16.62	$ -	$ 16.62	$ -
104	SA041	pack, basic injection										
105	SA048	pack, minimum multi-specialty visit			1		1					
106	SC028	needle, 18-26g 1.5-3.5in, spinal			1		1		1		1	
107	SK075	skin marking pen, sterile (Skin Skribe)										
108	SH021	bupivacaine 0.25% inj (Marcaine)	5		5		5		5		5	
109	SH023	chlorhexidine 0.12% (Peridex)										
110	SG056	gauze, sterile 4in x 4in (10 pack uou)			2		2					
111	SC053	syringe 20ml										
112	SB024	gloves, sterile	1						1		1	
113	SG055	gauze, sterile 4in x 4in	1						1		1	
114	SC029	needle, 18-27g	2						1		1	
115	SC051	syringe 10-12ml	1									
116	SG009	applicator, sponge-tipped	1									
117	SJ041	povidone soln (Betadine)	10									
118	SC034	needle, blunt tip			1		1					
119	SJ053	swab-pad, alcohol			2		2					
120	SH047	lidocaine 1%-2% inj (Xylocaine)							5		5	
121	SH022	bupivacaine 0.5% inj (Marcaine)										
122	SG021	bandage, strip 0.75in x 3in (Bandaid)			1		1		1		1	
123	SC057	syringe 5-6ml			1		1		2		2	
124	SC038	needle, epidural (RK)										
125	SA051	pack, pelvic exam										
126	SB006	drape, non-sterile, sheet 40in x 60in										
127	SJ052	swab, procto 16in										
128	SJ043	povidone swabsticks (3 pack uou)										
129	SA129	pudendal block tray, sterile										
130	SB001	cap, surgical							1		1	
131	SB033	mask, surgical							1		1	
132	SB007	drape, sterile barrier 16in x 29in							1		1	
133	SB012	drape, sterile, for Mayo stand							1		1	
134	SJ081	swab, patient prep, 1.5 ml (chloraprep)							1		1	
135	SJ001	alcohol isopropyl 70%										
136	SB028	gown, surgical, sterile										
137	SB027	gown, staff, impervious										
138	SB022	gloves, non-sterile										
139	SB026	gown, patient										
140	SB004	cover, thermometer probe										
141	SB036	paper, exam table										
142	SB044	underpad 2ft x 3ft (Chux)										
143	SB037	pillow case										
144	SB019	drape-towel, sterile 18in x 26in										
145	SB008	drape, sterile, c-arm, fluoro										
146	SD269	Grounding pad										
147	SD087	guide, needle, for localization										
148	SL259	Bleach cleaning wipe										
149												
150												
151		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
153	Equipment Code	EQUIPMENT										
154		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ 0.14	$ -	$ 0.26	$ -	$ 0.26	$ -	$ 0.27	$ -	$ 0.27	$ -
155	EF023	table, exam	16						20		20	
156	EF015	mayo stand			19		19		20		20	
157	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)										
158	EF008	chair with headrest, exam, reclining			19		19					
159	EQ168	light, exam							20		20	
160	EF031	table, power										
161	EL018	room, mobile c-ARM										
162	ED050	Technologist PACS workstation										
163	EF027	table, instrument, mobile										
164												
165		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED (Affirmation of Oct 2018 Inputs)**		**CURRENT**		**RECOMMENDED (Affirmation of Oct 2018 Inputs)**		**CURRENT**	
2			**64420**		**64420**		**64421**		**64421**		**64425**	
3		***RUC Collaboration Website***	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level		Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level		Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level		Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level		Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric	
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**000**	**000**	**000**	**000**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 38.14**	**$ 4.44**	**$ 38.14**	**$ 4.44**	**$ 7.17**	**$ -**	**$ 7.17**	**$ -**	**$ 52.77**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	**51.0**	**12.0**	**51.0**	**12.0**	**10.0**	**0.0**	**10.0**	**0.0**	**52.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**3.0**	**9.0**	**3.0**	**9.0**	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**45.0**	**0.0**	**45.0**	**0.0**	**10.0**	**0.0**	**10.0**	**0.0**	**46.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**	**3.0**	**3.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 18.87**	**$ 4.44**	**$ 18.87**	**$ 4.44**	**$ 3.70**	**$ -**	**$ 3.70**	**$ -**	**$ 19.24**	**$ 4.44**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001	Complete pre-service diagnostic and referral forms										
16	CA002	Coordinate pre-surgery services (including test results)		3		3						3
17	CA003	Schedule space and equipment in facility		3		3						3
18	CA004	Provide pre-service education/obtain consent										
19	CA005	Complete pre-procedure phone calls and prescription	3	3	3	3					3	3
20	CA006	Confirm availability of prior images/studies										
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)										
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	3		3						3	
34	CA010	Obtain vital signs	5		5						5	
35	CA011	Provide education/obtain consent	2		2						2	
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies	2		2						2	
38	CA013	Prepare room, equipment and supplies										
39	CA014	Confirm order, protocol exam										
40	CA015	Setup scope (nonfacility setting only)										
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2		2						2	
42	CA017	Sedate/apply anesthesia										
43												
46		*Other activity: please include short clinical description here and type*										
49		**Intra-service (of service period)**										
50	CA018	Assist physician or other qualified healthcare professional---directly	10		10		10		10		11	
51	CA018	Assist physician or other qualified healthcare professional---directly										
52	CA019	Assist physician or other qualified healthcare professional---directly										
53	CA020	Assist physician or other qualified healthcare professional---directly										
54	CA021	Perform procedure/service---NOT directly related to physician work time										
57												
58		*Other activity: please include short clinical description here and type*										
61		**Post-Service (of service period)**										
62	CA022	Monitor patient following procedure/service, multitasking 1:4	15		15						15	
63	CA023	Monitor patient following procedure/service, no multitasking										
64	CA024	Clean room/equipment by clinical staff	3		3						3	
65	CA025	Clean scope										
66	CA026	Clean surgical instrument package										
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
68	CA028	Review/read post-procedure x-ray, lab and pathology reports										
69	CA029	Check dressings, catheters, wounds	1		1						1	
70	CA030	Technologist QC's images in PACS, checking for all images, reformats,										
71	CA031	Review examination with interpreting MD/DO										
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to										
73	CA033	Perform regulatory mandated quality assurance activity (service period)										
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry										
75	CA035	Review home care instructions, coordinate visits/prescriptions	2		2						2	
76	CA036	Discharge day management	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
77												
80		*Other activity: please include short clinical description here and type*										
83		**End: Patient leaves office/facility**										
84		**POST-SERVICE PERIOD**										
85		**Start: Patient leaves office/facility**										
86	CA037	Conduct patient communications	3	3	3	3					3	3
87	CA038	Coordinate post-procedure services										
88		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes										
90		99212 27 minutes										
91		99213 36 minutes										
92		99214 53 minutes										
93		99215 63 minutes										
94	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
95												
98		*Other activity: please include short clinical description here and type*										
101		**End: with last office visit before end of global period**										

	A	B	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	RUC Practice Expense Spreadsheet		CURRENT		RECOMMENDED (Affirmation of Oct 2018 Inputs)		CURRENT		RECOMMENDED (Affirmation of Oct 2018 Inputs)		CURRENT	
2			64420		64420		64421		64421		64425	
3		*RUC Collaboration Website*	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level		Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level		Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level		Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, each additional level		Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric	
4	Clinical Activity Code	Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS										
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	000	000	000	000	ZZZ	ZZZ	ZZZ	ZZZ	000	000
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 38.14	$ 4.44	$ 38.14	$ 4.44	$ 7.17	$ -	$ 7.17	$ -	$ 52.77	$ 4.44
8		TOTAL CLINICAL STAFF TIME	51.0	12.0	51.0	12.0	10.0	0.0	10.0	0.0	52.0	12.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	3.0	9.0	3.0	9.0	0.0	0.0	0.0	0.0	3.0	9.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	45.0	0.0	45.0	0.0	10.0	0.0	10.0	0.0	46.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	3.0	0.0	0.0	0.0	0.0	3.0	3.0
102	Supply Code	MEDICAL SUPPLIES										
103		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ 18.02	$ -	$ 18.02	$ -	$ 2.60	$ -	$ 2.60	$ -	$ 32.26	$ -
104	SA041	pack, basic injection	1		1						1	
105	SA048	pack, minimum multi-specialty visit	1		1						1	
106	SC028	needle, 18-26g 1.5-3.5in, spinal										
107	SK075	skin marking pen, sterile (Skin Skribe)	1		1						1	
108	SH021	bupivacaine 0.25% inj (Marcaine)										
109	SH023	chlorhexidine 0.12% (Peridex)									1	
110	SG056	gauze, sterile 4in x 4in (10 pack uou)					1		1		2	
111	SC053	syringe 20ml					1		1			
112	SB024	gloves, sterile										
113	SG055	gauze, sterile 4in x 4in										
114	SC029	needle, 18-27g					1		1			
115	SC051	syringe 10-12ml	1		1						1	
116	SG009	applicator, sponge-tipped										
117	SJ041	povidone soln (Betadine)										
118	SC034	needle, blunt tip	1		1							
119	SJ053	swab-pad, alcohol	1		1							
120	SH047	lidocaine 1%-2% inj (Xylocaine)	5		5		2		2		10	
121	SH022	bupivacaine 0.5% inj (Marcaine)	5		5		2		2		10	
122	SG021	bandage, strip 0.75in x 3in (Bandaid)					1		1			
123	SC057	syringe 5-6ml									1	
124	SC038	needle, epidural (RK)									1	
125	SA051	pack, pelvic exam										
126	SB006	drape, non-sterile, sheet 40in x 60in										
127	SJ052	swab, procto 16in										
128	SJ043	povidone swabsticks (3 pack uou)										
129	SA129	pudendal block tray, sterile										
130	SB001	cap, surgical										
131	SB033	mask, surgical										
132	SB007	drape, sterile barrier 16in x 29in										
133	SB012	drape, sterile, for Mayo stand										
134	SJ081	swab, patient prep, 1.5 ml (chloraprep)										
135	SJ001	alcohol isopropyl 70%										
136	SB028	gown, surgical, sterile										
137	SB027	gown, staff, impervious										
138	SB022	gloves, non-sterile										
139	SB026	gown, patient										
140	SB004	cover, thermometer probe										
141	SB036	paper, exam table										
142	SB044	underpad 2ft x 3ft (Chux)										
143	SB037	pillow case										
144	SB019	drape-towel, sterile 18in x 26in										
145	SB008	drape, sterile, c-arm, fluoro										
146	SD269	Grounding pad										
147	SD087	guide, needle, for localization										
148	SL259	Bleach cleaning wipe										
149												
150												
151		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
153	Equipment Code	EQUIPMENT										
154		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ 1.25	$ -	$ 1.25	$ -	$ 0.87	$ -	$ 0.87	$ -	$ 1.27	$ -
155	EF023	table, exam	28		28		10		10		29	
156	EF015	mayo stand	28		28		10		10		29	
157	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	88		88		70		70		89	
158	EF008	chair with headrest, exam, reclining										
159	EQ168	light, exam										
160	EF031	table, power										
161	EL018	room, mobile c-ARM										
162	ED050	Technologist PACS workstation										
163	EF027	table, instrument, mobile										
164												
165		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
1	RUC Practice Expense Spreadsheet		RECOMMENDED (Affirmation of Oct 2018 Inputs)		CURRENT		RECOMMENDED (Affirmation of Oct 2018 Inputs)		CURRENT		RECOMMENDED (Affirmation of Oct 2018 Inputs)	
2			64425		64430		64430		64435		64435	
3		*RUC Collaboration Website*	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric		Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve		Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve		Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve		Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve	
4	Clinical Activity Code	Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS										
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	000	000	000	000	000	000	000	000	000	000
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 52.77	$ 4.44	$ 42.74	$ 4.07	$ 42.74	$ 4.07	$ 40.82	$ 4.07	$ 31.59	$ 4.07
8		TOTAL CLINICAL STAFF TIME	52.0	12.0	33.0	11.0	33.0	11.0	28.0	11.0	14.0	11.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	3.0	9.0	0.0	8.0	0.0	8.0	0.0	8.0	0.0	8.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	46.0	0.0	30.0	0.0	30.0	0.0	25.0	0.0	11.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ 19.24	$ 4.44	$ 12.21	$ 4.07	$ 12.21	$ 4.07	$ 10.36	$ 4.07	$ 5.18	$ 4.07
13		PRE-SERVICE PERIOD										
14		Start: Following visit when decision for surgery/procedure made										
15	CA001	Complete pre-service diagnostic and referral forms				3		3		3		3
16	CA002	Coordinate pre-surgery services (including test results)		3								
17	CA003	Schedule space and equipment in facility		3								
18	CA004	Provide pre-service education/obtain consent				5		5		5		5
19	CA005	Complete pre-procedure phone calls and prescription	3	3								
20	CA006	Confirm availability of prior images/studies										
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)										
23												
26		*Other activity: please include short clinical description here and type*										
29		End: When patient enters office/facility for surgery/procedure										
30		SERVICE PERIOD										
31		Start: When patient enters office/facility for surgery/procedure:										
32		Pre-Service (of service period)										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	3		3		3		3		0	
34	CA010	Obtain vital signs	5		5		5		5		0	
35	CA011	Provide education/obtain consent	2		2		2		2		0	
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies	2		2		2		2		0	
38	CA013	Prepare room, equipment and supplies										
39	CA014	Confirm order, protocol exam										
40	CA015	Setup scope (nonfacility setting only)										
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2		2		2		2		0	
42	CA017	Sedate/apply anesthesia										
43												
46		*Other activity: please include short clinical description here and type*										
49		Intra-service (of service period)										
50	CA018	Assist physician or other qualified healthcare professional---directly	11		10		10		5		5	
51	CA018	Assist physician or other qualified healthcare professional---directly										
52	CA019	Assist physician or other qualified healthcare professional---directly										
53	CA020	Assist physician or other qualified healthcare professional---directly										
54	CA021	Perform procedure/service---NOT directly related to physician work time										
57												
58		*Other activity: please include short clinical description here and type*										
61		Post-Service (of service period)										
62	CA022	Monitor patient following procedure/service, multitasking 1:4	15		3		3		3		3	
63	CA023	Monitor patient following procedure/service, no multitasking										
64	CA024	Clean room/equipment by clinical staff	3		3		3		3		3	
65	CA025	Clean scope										
66	CA026	Clean surgical instrument package										
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
68	CA028	Review/read post-procedure x-ray, lab and pathology reports										
69	CA029	Check dressings, catheters, wounds	1									
70	CA030	Technologist QC's images in PACS, checking for all images, reformats,										
71	CA031	Review examination with interpreting MD/DO										
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to										
73	CA033	Perform regulatory mandated quality assurance activity (service period)										
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry										
75	CA035	Review home care instructions, coordinate visits/prescriptions	2									
76	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a	
77												
80		*Other activity: please include short clinical description here and type*										
83		End: Patient leaves office/facility										
84		POST-SERVICE PERIOD										
85		Start: Patient leaves office/facility										
86	CA037	Conduct patient communications	3	3	3	3	3	3	3	3	3	3
87	CA038	Coordinate post-procedure services										
88		*Office visits: List Number and Level of Office Visits*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
89		99211 16 minutes										
90		99212 27 minutes										
91		99213 36 minutes										
92		99214 53 minutes										
93		99215 63 minutes										
94	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
95												
98		*Other activity: please include short clinical description here and type*										
101		End: with last office visit before end of global period										

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
1	RUC Practice Expense Spreadsheet		RECOMMENDED (Affirmation of Oct 2018 Inputs)		CURRENT		RECOMMENDED (Affirmation of Oct 2018 Inputs)		CURRENT		RECOMMENDED (Affirmation of Oct 2018 Inputs)	
2			64425		64430		64430		64435		64435	
3		*RUC Collaboration Website*	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric		Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve		Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve		Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve		Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve	
4	Clinical Activity Code	Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS										
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	000	000	000	000	000	000	000	000	000	000
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 52.77	$ 4.44	$ 42.74	$ 4.07	$ 42.74	$ 4.07	$ 40.82	$ 4.07	$ 31.59	$ 4.07
8		TOTAL CLINICAL STAFF TIME	52.0	12.0	33.0	11.0	33.0	11.0	28.0	11.0	14.0	11.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	3.0	9.0	0.0	8.0	0.0	8.0	0.0	8.0	0.0	8.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	46.0	0.0	30.0	0.0	30.0	0.0	25.0	0.0	11.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
102	Supply Code	MEDICAL SUPPLIES										
103		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ 32.26	$ -	$ 30.17	$ -	$ 30.17	$ -	$ 30.17	$ -	$ 26.12	$ -
104	SA041	pack, basic injection	1									
105	SA048	pack, minimum multi-specialty visit	1		1		1		1		0	
106	SC028	needle, 18-26g 1.5-3.5in, spinal										
107	SK075	skin marking pen, sterile (Skin Skribe)	1									
108	SH021	bupivacaine 0.25% inj (Marcaine)			10		10		10		10	
109	SH023	chlorhexidine 0.12% (Peridex)	1									
110	SG056	gauze, sterile 4in x 4in (10 pack uou)	2									
111	SC053	syringe 20ml										
112	SB024	gloves, sterile										
113	SG055	gauze, sterile 4in x 4in										
114	SC029	needle, 18-27g										
115	SC051	syringe 10-12ml	1									
116	SG009	applicator, sponge-tipped										
117	SJ041	povidone soln (Betadine)										
118	SC034	needle, blunt tip										
119	SJ053	swab-pad, alcohol										
120	SH047	lidocaine 1%-2% inj (Xylocaine)	10									
121	SH022	bupivacaine 0.5% inj (Marcaine)	10									
122	SG021	bandage, strip 0.75in x 3in (Bandaid)										
123	SC057	syringe 5-6ml	1									
124	SC038	needle, epidural (RK)	1									
125	SA051	pack, pelvic exam			1		1		1		1	
126	SB006	drape, non-sterile, sheet 40in x 60in			1		1		1		1	
127	SJ052	swab, procto 16in			2		2		2		2	
128	SJ043	povidone swabsticks (3 pack uou)			1		1		1		1	
129	SA129	pudendal block tray, sterile			1		1		1		1	
130	SB001	cap, surgical										
131	SB033	mask, surgical										
132	SB007	drape, sterile barrier 16in x 29in										
133	SB012	drape, sterile, for Mayo stand										
134	SJ081	swab, patient prep, 1.5 ml (chloraprep)										
135	SJ001	alcohol isopropyl 70%										
136	SB028	gown, surgical, sterile										
137	SB027	gown, staff, impervious										
138	SB022	gloves, non-sterile										
139	SB026	gown, patient										
140	SB004	cover, thermometer probe										
141	SB036	paper, exam table										
142	SB044	underpad 2ft x 3ft (Chux)										
143	SB037	pillow case										
144	SB019	drape-towel, sterile 18in x 26in										
145	SB008	drape, sterile, c-arm, fluoro										
146	SD269	Grounding pad										
147	SD087	guide, needle, for localization										
148	SL259	Bleach cleaning wipe										
149												
150												
151		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
153	Equipment Code	EQUIPMENT										
154		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ 1.27	$ -	$ 0.36	$ -	$ 0.36	$ -	$ 0.30	$ -	$ 0.30	$ -
155	EF023	table, exam	29		27		27		22		22	
156	EF015	mayo stand	29									
157	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	89									
158	EF008	chair with headrest, exam, reclining										
159	EQ168	light, exam			27		27		22		22	
160	EF031	table, power										
161	EL018	room, mobile c-ARM										
162	ED050	Technologist PACS workstation										
163	EF027	table, instrument, mobile			27		27		22		22	
164												
165		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED (Affirmation of Oct 2018 Inputs)**		**CURRENT**		**RECOMMENDED (Affirmation of Jan 2019 Inputs)**		**CURRENT**	
2			**64449**		**64449**		**64450**		**64450**		**64451**	
3		***RUC Collaboration Website***	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach,		Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach,		Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint,	
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 4.44**	**$ -**	**$ 4.44**	**$ 33.37**	**$ 4.44**	**$ 33.37**	**$ 4.44**	**$123.12**	**$ 4.07**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**12.0**	**0.0**	**12.0**	**37.0**	**12.0**	**37.0**	**12.0**	**68.0**	**11.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**9.0**	**0.0**	**9.0**	**3.0**	**9.0**	**3.0**	**9.0**	**5.0**	**11.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**31.0**	**0.0**	**31.0**	**0.0**	**63.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**3.0**	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ 4.44**	**$ -**	**$ 4.44**	**$ 13.69**	**$ 4.44**	**$ 13.69**	**$ 4.44**	**$ 26.04**	**$ 4.07**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001	Complete pre-service diagnostic and referral forms										
16	CA002	Coordinate pre-surgery services (including test results)		3		3		3		3		3
17	CA003	Schedule space and equipment in facility		3		3		3		3		3
18	CA004	Provide pre-service education/obtain consent										
19	CA005	Complete pre-procedure phone calls and prescription		3		3	3	3	3	3	3	3
20	CA006	Confirm availability of prior images/studies									2	2
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)										
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are					3		3		3	
34	CA010	Obtain vital signs					5		5		5	
35	CA011	Provide education/obtain consent					3		3		2	
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies					2		2		2	
38	CA013	Prepare room, equipment and supplies									2	
39	CA014	Confirm order, protocol exam									1	
40	CA015	Setup scope (nonfacility setting only)										
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient					2		2		2	
42	CA017	Sedate/apply anesthesia										
43												
46		*Other activity: please include short clinical description here and type*										
49		**Intra-service (of service period)**										
50	CA018	Assist physician or other qualified healthcare professional---directly					5		5		15	
51	CA018	Assist physician or other qualified healthcare professional---directly									15	
52	CA019	Assist physician or other qualified healthcare professional---directly										
53	CA020	Assist physician or other qualified healthcare professional---directly										
54	CA021	Perform procedure/service---NOT directly related to physician work time										
57												
58		*Other activity: please include short clinical description here and type*										
61		**Post-Service (of service period)**										
62	CA022	Monitor patient following procedure/service, multitasking 1:4					5		5		5	
63	CA023	Monitor patient following procedure/service, no multitasking										
64	CA024	Clean room/equipment by clinical staff					3		3		3	
65	CA025	Clean scope										
66	CA026	Clean surgical instrument package										
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
68	CA028	Review/read post-procedure x-ray, lab and pathology reports										
69	CA029	Check dressings, catheters, wounds					1		1		1	
70	CA030	Technologist QC's images in PACS, checking for all images, reformats,									2	
71	CA031	Review examination with interpreting MD/DO									2	
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to									1	
73	CA033	Perform regulatory mandated quality assurance activity (service period)										
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry										
75	CA035	Review home care instructions, coordinate visits/prescriptions					2		2		2	
76	CA036	Discharge day management	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
77												
80		*Other activity: please include short clinical description here and type*										
83		**End: Patient leaves office/facility**										
84		**POST-SERVICE PERIOD**										
85		**Start: Patient leaves office/facility**										
86	CA037	Conduct patient communications		3		3	3	3	3	3		
87	CA038	Coordinate post-procedure services										
88		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes										
90		99212 27 minutes										
91		99213 36 minutes										
92		99214 53 minutes										
93		99215 63 minutes										
94	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
95												
98		*Other activity: please include short clinical description here and type*										
101		**End: with last office visit before end of global period**										

	A	B	AS	AT	AU	AV	AW	AX	AY	AZ	BA	BB
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED (Affirmation of Oct 2018 Inputs)**		**CURRENT**		**RECOMMENDED (Affirmation of Jan 2019 Inputs)**		**CURRENT**	
2			**64449**		**64449**		**64450**		**64450**		**64451**	
3		***RUC Collaboration Website***	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach,		Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach,		Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint,	
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ 4.44**	**$ -**	**$ 4.44**	**$ 33.37**	**$ 4.44**	**$ 33.37**	**$ 4.44**	**$123.12**	**$ 4.07**
8		**TOTAL CLINICAL STAFF TIME**	**0.0**	**12.0**	**0.0**	**12.0**	**37.0**	**12.0**	**37.0**	**12.0**	**68.0**	**11.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**9.0**	**0.0**	**9.0**	**3.0**	**9.0**	**3.0**	**9.0**	**5.0**	**11.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**31.0**	**0.0**	**31.0**	**0.0**	**63.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**3.0**	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**
102	**Supply Code**	**MEDICAL SUPPLIES**										
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 18.51**	**$ -**	**$ 18.51**	**$ -**	**$ 82.21**	**$ -**
104	SA041	pack, basic injection					1		1			
105	SA048	pack, minimum multi-specialty visit					1		1			
106	SC028	needle, 18-26g 1.5-3.5in, spinal									4	
107	SK075	skin marking pen, sterile (Skin Skribe)					1		1		1	
108	SH021	bupivacaine 0.25% inj (Marcaine)									5	
109	SH023	chlorhexidine 0.12% (Peridex)					1		1			
110	SG056	gauze, sterile 4in x 4in (10 pack uou)									1	
111	SC053	syringe 20ml										
112	SB024	gloves, sterile									1	
113	SG055	gauze, sterile 4in x 4in					2		2			
114	SC029	needle, 18-27g									1	
115	SC051	syringe 10-12ml					1		1		2	
116	SG009	applicator, sponge-tipped										
117	SJ041	povidone soln (Betadine)										
118	SC034	needle, blunt tip										
119	SJ053	swab-pad, alcohol										
120	SH047	lidocaine 1%-2% inj (Xylocaine)					5		5		10	
121	SH022	bupivacaine 0.5% inj (Marcaine)					5		5		5	
122	SG021	bandage, strip 0.75in x 3in (Bandaid)									3	
123	SC057	syringe 5-6ml										
124	SC038	needle, epidural (RK)										
125	SA051	pack, pelvic exam										
126	SB006	drape, non-sterile, sheet 40in x 60in										
127	SJ052	swab, procto 16in										
128	SJ043	povidone swabsticks (3 pack uou)										
129	SA129	pudendal block tray, sterile										
130	SB001	cap, surgical									1	
131	SB033	mask, surgical									3	
132	SB007	drape, sterile barrier 16in x 29in										
133	SB012	drape, sterile, for Mayo stand									1	
134	SJ081	swab, patient prep, 1.5 ml (chloraprep)									2	
135	SJ001	alcohol isopropyl 70%					5		5		5	
136	SB028	gown, surgical, sterile									1	
137	SB027	gown, staff, impervious									1	
138	SB022	gloves, non-sterile									1	
139	SB026	gown, patient									1	
140	SB004	cover, thermometer probe									1	
141	SB036	paper, exam table									7	
142	SB044	underpad 2ft x 3ft (Chux)									1	
143	SB037	pillow case									2	
144	SB019	drape-towel, sterile 18in x 26in									4	
145	SB008	drape, sterile, c-arm, fluoro									1	
146	SD269	Grounding pad										
147	SD087	guide, needle, for localization									1	
148	SL259	Bleach cleaning wipe									2	
149												
150												
151		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
153	**Equipment Code**	**EQUIPMENT**										
154		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 1.17**	**$ -**	**$ 1.17**	**$ -**	**$ 14.87**	**$ -**
155	EF023	table, exam					24		24			
156	EF015	mayo stand					24		24		36	
157	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)					84		84		56	
158	EF008	chair with headrest, exam, reclining										
159	EQ168	light, exam									36	
160	EF031	table, power									36	
161	EL018	room, mobile c-ARM									22	
162	ED050	Technologist PACS workstation									41	
163	EF027	table, instrument, mobile										
164												
165		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	BC	BD	BE	BF	BG	BH	BI	BJ	BK	BL
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED (Affirmation of Jan 2019 Inputs)**		**CURRENT**		**RECOMMENDED (Affirmation of Jan 2019 Inputs)**		**CURRENT**		**RECOMMENDED (Affirmation of April 2017 Inputs)**	
2			**64451**		**64454**		**64454**		**64455**		**64455**	
3		***RUC Collaboration Website***	Injection(s),		Injection(s),		Injection(s),		Injection(s),		Injection(s),	
4	**Clinical Activity Code**	**Meeting Date: October 2021** **Revision Date (if applicable):** **Tab: 5** **Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS**	anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint,		anesthetic agent(s) and/or steroid; genicular nerve branches, including		anesthetic agent(s) and/or steroid; genicular nerve branches, including		anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg,		anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg,	
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**000**	**000**	**000**	**000**	**000**	**000**	**000**		**000**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$123.12**	**$ 4.07**	**$120.64**	**$ 5.18**	**$120.64**	**$ 5.18**	**$ 13.08**	**$ -**	**$ 11.23**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**68.0**	**11.0**	**78.0**	**14.0**	**78.0**	**14.0**	**19.0**	**0.0**	**14.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**5.0**	**11.0**	**5.0**	**11.0**	**5.0**	**11.0**	**0.0**	**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**63.0**	**0.0**	**70.0**	**0.0**	**70.0**	**0.0**	**19.0**	**0.0**	**14.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**	**3.0**	**3.0**	**3.0**	**3.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 26.04**	**$ 4.07**	**$ 29.86**	**$ 5.18**	**$ 29.86**	**$ 5.18**	**$ 7.03**	**$ -**	**$ 5.18**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001	Complete pre-service diagnostic and referral forms										
16	CA002	Coordinate pre-surgery services (including test results)		3		3		3				
17	CA003	Schedule space and equipment in facility		3		3		3				
18	CA004	Provide pre-service education/obtain consent										
19	CA005	Complete pre-procedure phone calls and prescription	3	3	3	3	3	3				
20	CA006	Confirm availability of prior images/studies	2	2	2	2	2	2				
21	CA007	Review patient clinical extant information and questionnaire										
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)										
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	3		3		3					
34	CA010	Obtain vital signs	5		5		5					
35	CA011	Provide education/obtain consent	2		3		3		3		0	
36	CA012	Review requisition, assess for special needs										
37	CA013	Prepare room, equipment and supplies	2		2		2		2		0	
38	CA013	Prepare room, equipment and supplies	2		2		2					
39	CA014	Confirm order, protocol exam	1		1		1					
40	CA015	Setup scope (nonfacility setting only)										
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2		2		2					
42	CA017	Sedate/apply anesthesia										
43												
46		*Other activity: please include short clinical description here and type*										
49		**Intra-service (of service period)**										
50	CA018	Assist physician or other qualified healthcare professional---directly	15		18		18		5		5	
51	CA018	Assist physician or other qualified healthcare professional---directly	15		18		18					
52	CA019	Assist physician or other qualified healthcare professional---directly										
53	CA020	Assist physician or other qualified healthcare professional---directly										
54	CA021	Perform procedure/service---NOT directly related to physician work time										
57												
58		*Other activity: please include short clinical description here and type*										
61		**Post-Service (of service period)**										
62	CA022	Monitor patient following procedure/service, multitasking 1:4	5		5		5		3		3	
63	CA023	Monitor patient following procedure/service, no multitasking										
64	CA024	Clean room/equipment by clinical staff	3		3		3		3		3	
65	CA025	Clean scope										
66	CA026	Clean surgical instrument package										
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions										
68	CA028	Review/read post-procedure x-ray, lab and pathology reports										
69	CA029	Check dressings, catheters, wounds	1		1		1		1		1	
70	CA030	Technologist QC's images in PACS, checking for all images, reformats,	2		2		2					
71	CA031	Review examination with interpreting MD/DO	2		2		2					
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to	1		1		1					
73	CA033	Perform regulatory mandated quality assurance activity (service period)										
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry										
75	CA035	Review home care instructions, coordinate visits/prescriptions	2		2		2		2		2	
76	CA036	Discharge day management	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
77												
80		*Other activity: please include short clinical description here and type*										
83		**End: Patient leaves office/facility**										
84		**POST-SERVICE PERIOD**										
85		**Start: Patient leaves office/facility**										
86	CA037	Conduct patient communications			3	3	3	3				
87	CA038	Coordinate post-procedure services										
88		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes										
90		99212 27 minutes										
91		99213 36 minutes										
92		99214 53 minutes										
93		99215 63 minutes										
94	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
95												
98		*Other activity: please include short clinical description here and type*										
101		**End: with last office visit before end of global period**										

	A	B	BC	BD	BE	BF	BG	BH	BI	BJ	BK	BL
1	RUC Practice Expense Spreadsheet		RECOMMENDED (Affirmation of Jan 2019 Inputs)		CURRENT		RECOMMENDED (Affirmation of Jan 2019 Inputs)		CURRENT		RECOMMENDED (Affirmation of April 2017 Inputs)	
2			64451		64454		64454		64455		64455	
3		*RUC Collaboration Website*	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint,		Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including		Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including		Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg,		Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg,	
4	Clinical Activity Code	Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: AAN, AAPM, AAPMR, APMA, ASA, NANS, SIS										
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	000	000	000	000	000	000	000		000	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$123.12	$ 4.07	$120.64	$ 5.18	$120.64	$ 5.18	$ 13.08	$ -	$ 11.23	$ -
8		TOTAL CLINICAL STAFF TIME	68.0	11.0	78.0	14.0	78.0	14.0	19.0	0.0	14.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	5.0	11.0	5.0	11.0	5.0	11.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	63.0	0.0	70.0	0.0	70.0	0.0	19.0	0.0	14.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	0.0	3.0	3.0	3.0	3.0	0.0	0.0	0.0	0.0
102	Supply Code	MEDICAL SUPPLIES										
103		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ 82.21	$ -	$ 73.98	$ -	$ 73.98	$ -	$ 5.89	$ -	$ 5.89	$ -
104	SA041	pack, basic injection										
105	SA048	pack, minimum multi-specialty visit										
106	SC028	needle, 18-26g 1.5-3.5in, spinal	4		3		3					
107	SK075	skin marking pen, sterile (Skin Skribe)	1		1		1					
108	SH021	bupivacaine 0.25% inj (Marcaine)	5									
109	SH023	chlorhexidine 0.12% (Peridex)										
110	SG056	gauze, sterile 4in x 4in (10 pack uou)	1		1		1		1		1	
111	SC053	syringe 20ml										
112	SB024	gloves, sterile	1		1		1		1		1	
113	SG055	gauze, sterile 4in x 4in										
114	SC029	needle, 18-27g	1		1		1		2		2	
115	SC051	syringe 10-12ml	2		2		2		1		1	
116	SG009	applicator, sponge-tipped										
117	SJ041	povidone soln (Betadine)							10		10	
118	SC034	needle, blunt tip										
119	SJ053	swab-pad, alcohol							2		2	
120	SH047	lidocaine 1%-2% inj (Xylocaine)	10		10		10		2		2	
121	SH022	bupivacaine 0.5% inj (Marcaine)	5		5		5					
122	SG021	bandage, strip 0.75in x 3in (Bandaid)	3		3		3		1		1	
123	SC057	syringe 5-6ml										
124	SC038	needle, epidural (RK)										
125	SA051	pack, pelvic exam										
126	SB006	drape, non-sterile, sheet 40in x 60in										
127	SJ052	swab, procto 16in										
128	SJ043	povidone swabsticks (3 pack uou)										
129	SA129	pudendal block tray, sterile										
130	SB001	cap, surgical	1		1		1					
131	SB033	mask, surgical	3		3		3					
132	SB007	drape, sterile barrier 16in x 29in							1		1	
133	SB012	drape, sterile, for Mayo stand	1		1		1					
134	SJ081	swab, patient prep, 1.5 ml (chloraprep)	2		2		2					
135	SJ001	alcohol isopropyl 70%	5		5		5					
136	SB028	gown, surgical, sterile	1		1		1					
137	SB027	gown, staff, impervious	1		1		1					
138	SB022	gloves, non-sterile	1		1		1					
139	SB026	gown, patient	1		1		1					
140	SB004	cover, thermometer probe	1		1		1					
141	SB036	paper, exam table	7		7		7					
142	SB044	underpad 2ft x 3ft (Chux)	1		1		1					
143	SB037	pillow case	2		2		2					
144	SB019	drape-towel, sterile 18in x 26in	4		4		4					
145	SB008	drape, sterile, c-arm, fluoro	1		1		1					
146	SD269	Grounding pad			1		1					
147	SD087	guide, needle, for localization	1		1		1					
148	SL259	Bleach cleaning wipe	2		2		2					
149												
150												
151		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
153	Equipment Code	EQUIPMENT										
154		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ 14.87	$ -	$ 16.80	$ -	$ 16.80	$ -	$ 0.16	$ -	$ 0.16	$ -
155	EF023	table, exam							19		19	
156	EF015	mayo stand	36		40		40					
157	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	56		60		60					
158	EF008	chair with headrest, exam, reclining										
159	EQ168	light, exam	36		40		40					
160	EF031	table, power	36		40		40					
161	EL018	room, mobile c-ARM	22		25		25					
162	ED050	Technologist PACS workstation	41		45		45					
163	EF027	table, instrument, mobile										
164												
165		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	D	E	F	I	K	M	O	Q	S
1	**RUC Practice Expense Spreadsheet**					**CURRENT**	**RECOMMENDED**	**CURRENT**	**RECOMMENDED**	**CURRENT**	**RECOMMENDED**
2						**76942**	**76942**	**77002**	**77002**	**77003**	**77003**
3		***RUC Collaboration Website***				Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation **(Oct 2017)**	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation **(Oct 2021)**	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure) **(Oct 2017)**	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure) **(Oct 2021)**	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure) **(Oct 2015)**	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure) **(Oct 2021)**
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: ACR, SIR, SIS, AAPM, AAPM&R, ASA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 21.99**	**$ 22.25**	**$ 68.08**	**$ 69.05**	**$ 68.08**	**$ 69.05**
8		**TOTAL CLINICAL STAFF TIME**				**29.0**	**29.0**	**29.0**	**29.0**	**29.0**	**29.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**2.0**	**2.0**				
10			L041B	Radiologic Technologist	0.41			**4.0**	**4.0**	**4.0**	**4.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**27.0**	**27.0**				
12			L041B	Radiologic Technologist	0.41			**25.0**	**25.0**	**25.0**	**25.0**
13		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**				
14		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 10.73**	**$ 10.73**	**$ 11.89**	**$ 11.89**	**$ 11.89**	**$ 11.89**
15		**PRE-SERVICE PERIOD**									
16		**Start: Following visit when decision for surgery/procedure made**									
17	CA001	Complete pre-service diagnostic and referral forms									
18	CA002	Coordinate pre-surgery services (including test									
19	CA003	Schedule space and equipment in facility									
20	CA004	Provide pre-service education/obtain consent									
21	CA005	Complete pre-procedure phone calls and prescription									
22	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37	**2**	**2**				
23	CA006	Confirm availability of prior images/studies	L041B	Radiologic Technologist	0.41			**2**	**2**	**2**	**2**
24	CA007	Review patient clinical extant information and questionnaire	L041B	Radiologic Technologist	0.41			**2**	**2**	**2**	**2**
25	CA008	Perform regulatory mandated quality assurance									
32		**End: When patient enters office/facility for surgery/procedure**									
33		**SERVICE PERIOD**									
34		**Start: When patient enters office/facility for surgery/procedure:**									
35		**Pre-Service (of service period)**									
36	CA009	Greet patient, provide gowning, ensure appropriate									
37	CA010	Obtain vital signs									
38	CA011	Provide education/obtain consent									
39	CA012	Review requisition, assess for special needs									
40	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	**2**	**2**				
41	CA014	Confirm order, protocol exam									
42	CA015	Setup scope (nonfacility setting only)									
43	CA016	Prepare, set-up and start IV, initial positioning and	L037D	RN/LPN/MTA	0.37	**2**	**2**				
44	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L041B	Radiologic Technologist	0.41			**2**	**2**	**2**	**2**
45	CA017	Sedate/apply anesthesia									
52		**Intra-service (of service period)**									
53	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	L041B	Radiologic Technologist	0.41			**15**	**15**	**15**	**15**
54	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	L037D	RN/LPN/MTA	0.37		**15**				
55	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)									
56	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)									
57	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37	**15**					
64		**Post-Service (of service period)**									
65	CA022	Monitor patient following procedure/service,									
66	CA023	Monitor patient following procedure/service, no									
67	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	**3**	**3**				

	A	B	D	E	F	I	K	M	O	Q	S
1	**RUC Practice Expense Spreadsheet**					**CURRENT**	**RECOMMENDED**	**CURRENT**	**RECOMMENDED**	**CURRENT**	**RECOMMENDED**
2						**76942**	**76942**	**77002**	**77002**	**77003**	**77003**
3		***RUC Collaboration Website***				Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation **(Oct 2017)**	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation **(Oct 2021)**	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure) **(Oct 2017)**	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure) **(Oct 2021)**	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure) **(Oct 2015)**	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure) **(Oct 2021)**
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 5 Specialty: ACR, SIR, SIS, AAPM, AAPM&R, ASA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**ZZZ**	**ZZZ**	**ZZZ**	**ZZZ**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 21.99**	**$ 22.25**	**$ 68.08**	**$ 69.05**	**$ 68.08**	**$ 69.05**
8		**TOTAL CLINICAL STAFF TIME**				**29.0**	**29.0**	**29.0**	**29.0**	**29.0**	**29.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**2.0**	**2.0**				
10			L041B	Radiologic Technologist	0.41			**4.0**	**4.0**	**4.0**	**4.0**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**27.0**	**27.0**				
12			L041B	Radiologic Technologist	0.41			**25.0**	**25.0**	**25.0**	**25.0**
13		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**				
68	CA024	Clean room/equipment by clinical staff	L041B	Radiologic	0.41			**3**	**3**	**3**	**3**
69	CA025	Clean scope									
70	CA026	Clean surgical instrument package									
71	CA027	Complete post-procedure diagnostic forms, lab and x-									
72	CA028	Review/read post-procedure x-ray, lab and pathology									
73	CA029	Check dressings, catheters, wounds									
74	CA030	Technologist QC's images in PACS, checking for all	L037D	RN/LPN/MTA	0.37	**2**	**2**				
75	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	L041B	Radiologic Technologist	0.41			**2**	**2**	**2**	**2**
76	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37	**2**	**2**				
77	CA031	Review examination with interpreting MD/DO	L041B	Radiologic Technologist	0.41			**2**	**2**	**2**	**2**
78	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	L037D	RN/LPN/MTA	0.37	**1**	**1**				
79	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	L041B	Radiologic Technologist	0.41			**1**	**1**	**1**	**1**
80	CA033	Perform regulatory mandated quality assurance									
81	CA034	Document procedure (nonPACS) (e.g. mandated									
82	CA035	Review home care instructions, coordinate									
83	CA036	Discharge day management				**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
90		**End: Patient leaves office/facility**									
91		**POST-SERVICE PERIOD**									
109	**Supply**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
110		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 6.21**	**$ 6.21**	**$ 5.58**	**$ 5.58**	**$ 5.58**	**$ 5.58**
111	SB005	cover-condom, transducer or ultrasound probe	3.4325	item		**1**	**1**				
112	SB008	drape, sterile, c-arm, fluoro	5.161	item				**1**	**1**	**1**	**1**
113	SB022	gloves, non-sterile	0.246	pair				**1**	**1**	**1**	**1**
114	SJ033	lubricating jelly (Surgilube)	0.5527	oz		**4**	**4**				
115	SM012	disinfectant spray (Transeptic)	0.0445	ml		**10**	**10**				
116	SM013	disinfectant, surface (Envirocide, Sanizide)	0.1758	oz				**1**	**1**	**1**	**1**
117	SM021	sanitizing cloth-wipe (patient)	0.0617	item		**2**	**2**				
121	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
122		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 5.05**	**$ 5.31**	**$ 50.61**	**$ 51.58**	**$ 50.61**	**$ 51.58**
123	ED050	Technologist PACS workstation	5557	PACS	0.022018	**15**	**27**	**25**	**25**	**25**	**25**
124	ED053	Professional PACS Workstation	15254.986	Other Formula	0.060443	**19**	**19**		**16**		**16**
125	EL014	room, radiographic-fluoroscopic	600544.45	Highly Technical	2.275474			**22**	**22**	**22**	**22**
126	EQ250	ultrasound unit, portable	38709.15	Highly Technical	0.150003	**24**	**24**				

September 9, 2021

Ezequiel Silva III, MD
Chair, RVS Update Committee (RUC)
American Medical Association
330 N. Wabash Ave., Suite 39300
Chicago, Illinois 60611

Dear Chairperson Ezequiel Silva,

CPT® codes 64445 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve*) and 64447 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve*) have been surveyed by the American Society of Anesthesiologists (ASA) and the American Society of Interventional Pain Physicians (ASIPP) for the October 2021 RUC meeting. They are part of Tab 5.

The RUC database indicates that, in the non-facility setting family physicians are the dominant specialty, reporting at 36 percent and 57 percent respectively. As a result, RUC staff directed the American Academy of Family Physicians (AAFP) to review the practice expense (PE) recommendations prepared by ASA and ASIPP prior to their submission.

The specialties were confused by the apparent reporting of these services by family physicians since these are not procedures that would typically be provided by non-anesthesiologists. Upon further research, the specialties have determined that the family medicine non-facility billings are likely a result of inappropriate reporting.

The specialties analyzed the public 2019 Physician Supplier Procedure Summary (PSPS) file and found that Fort Worth Texas is responsible for 64% of all family medicine claims for CPT 64445, and 89% of all family medicine claims for 64447. The large concentration of family medicine non-facility claims in one locality area suggests these family medicine claims are likely inappropriately reported.

Based on these findings, the societies believe there is no need for the AAFP to review the PE recommendations. As such the PE recommendations were not reviewed by the AAFP.

Sincerely,

Megan Adamson, MD,
AAFP RUC Advisor

Richard Rosenquist, MD
ASA RUC Advisor

Michael Lubrano, MD
ASIPP RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS 000-Day Global Typically Reported with an E/M

April 2017

Injection – Digital Nerves

In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an Evaluation and Management (E/M) service 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000. CPT code 64455 was identified on this list.

64455 ***Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)***
The RUC reviewed the survey results from 205 orthopaedic surgeons, foot and ankle surgeons and podiatrists and determined that the current value of 0.75, which was also the survey 25th percentile and median, appropriately accounts for the work required to perform this service. The specialty societies recommended pre-time package 6, but reduced the package evaluation time from 17 minutes to 5 minutes to account for overlap in time with an E/M reported on the same day. The RUC carefully examined potential overlap with E/M services included in CPT code 64455 and recommends 5 minutes evaluation time, 1 minute positioning time, 5 minutes scrub/dress/wait time, 5 minutes of intra-service time and 5 minutes of post-service time. The five minutes of evaluation time includes time to obtain consent after discussion of possible complications and preparing for the procedure which includes confirming availability of necessary supplies and instruments and preparation of syringes; one with local anesthetic and one with mixed anesthetic and steroid. The one minute for positioning includes both positioning the patient for the injection and confirming the injection site. The five minutes for scrub/dress/wait time accounts for prepping the injection site, injecting the local anesthetic and waiting for anesthetic effect.

The RUC compared CPT code 64455 to the top two key reference services 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (work RVU = 0.75) and 20550 *Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")* (work RVU = 0.75) and agreed that all three injections would require the same physician work and time justifying maintaining the current value. For additional support the RUC referenced MPC codes 67820 *Correction of trichiasis; epilation, by forceps only* (work RVU = 0.71) and 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84). **The RUC recommends a work RVU of 0.75 for CPT code 64455.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1

paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Practice Expense

The Practice Expense Subcommittee reduced the time to *Prepare room, equipment and supplies* (CA013) from 3 minutes to the standard of 2 minutes. The PE Subcommittee discussed the potential for overlap with the evaluation and management service with the time for preparing the room, supplies and equipment. It was determined that this time addresses the preparation of the supplies related directly to the injection itself including logging injectables (eg, name, lot, expiration date) into the medical record and does not overlap with preparing the room for an E/M visit. CMS staff questioned whether the patients present with pain only and tried to discern any overlap with E/M. The specialties explained that it is typical to first examine the patient to determine where the pain is coming from and to determine if an injection or another procedure is medically necessary. Often times, the initial treatment is conservative medical management. In addition, the PE Subcommittee discussed the potential for overlap with E/M with the time for clean room/equipment. It was determined that the cleaning time for this code addresses the cleaning of supplies related directly to the injection itself, including sharps disposal and logging injectables back into storage, and was appropriate. Additionally the RUC removed the *exam light* (EQ168) as it would not typically be used for this service and would not be in a standard room used for evaluation and management. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)	000	0.75 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64455 Tracking Number n/a Original Specialty Recommended RVU: **0.75**
Presented Recommended RVU: **0.75**
Global Period: 000 Current Work RVU: **0.75** RUC Recommended RVU: **0.75**

CPT Descriptor: Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 46-year-old female presents with a painful neuroma in the third intermetatarsal space of her right foot. The decision is made to proceed with a therapeutic intermetatarsal neuroma injection.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The procedure is explained to the patient and family, possible complications are discussed, and consent is obtained. Availability of necessary supplies and instruments is verified. Gloves are donned. Syringes are prepared, one with local anesthetic and one with mixed anesthetic and steroid. The patient and extremity are positioned and the injection site is confirmed. The injection site is prepped and local anesthetic is infiltrated.

Description of Intra-Service Work: Palpate the intermetatarsal space and identify the point of maximal tenderness. Utilize a dorsal approach and insert the needle top to bottom without penetrating the plantar skin. Deposit a portion of the injectable solution. Redirect the needle distally and medially without exiting the dorsal site and deposit a portion of the injectable solution. Again redirect the needle distally and laterally without exiting the dorsal site and deposit the final portion of the injectable solution.

Description of Post-Service Work: Cleanse the injection area and apply a bandage. Monitor the patient for any potential complications from the injection. Instruct patient and/or caregiver on appropriate activities and home care, including bathing restrictions. Advise the patient regarding signs related to increased pain at the injection site, which may occur within 24 to 48 hours, and the appropriate treatment if pain occurs. Document the procedure in the patient's medical record and send a copy to the primary care physician and insurance.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2017				
Presenter(s):	Brooke Bisbee, DPM; Lloyd Smith, DPM; William Creevy, MD; John Heiner, MD; Peter Mangone, MD				
Specialty(s):	APMA, AAOS, AOFAS				
CPT Code:	64455				
Sample Size:	2132	**Resp N:**	205	**Response:** 9.6 %	
Description of Sample:	Random selection from each society membership database				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	15.00	**30.00**	60.00	500.00
Survey RVW:	0.50	0.75	**0.75**	0.85	1.70
Pre-Service Evaluation Time:			**12.00**		
Pre-Service Positioning Time:			**2.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	3.00	**5.00**	5.00	15.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	64455	**Recommended Physician Work RVU: 0.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**17.00**	**-12.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**5.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**		**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64450	000	0.75	**RUC Time**

CPT Descriptor Injection, anesthetic agent; other peripheral nerve or branch

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
20550	000	0.75	**RUC Time**

CPT Descriptor Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67820	000	0.71	**RUC Time**	247,521

CPT Descriptor 1 Correction of trichiasis; epilation, by forceps only

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
12001	000	0.84	**RUC Time**	188,177

CPT Descriptor 2 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 118 **% of respondents:** 57.5 **%**

Number of respondents who choose 2nd Key Reference Code: 26 **% of respondents:** 12.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 64455	Top Key Reference CPT Code: 64450	2nd Key Reference CPT Code: **20550**
Median Pre-Service Time	11.00	11.00	11.00
Median Intra-Service Time	5.00	5.00	5.00
Median Immediate Post-service Time	5.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**21.00**	**21.00**	**21.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	1%	4%	62%	33%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
The number of possible diagnosis and/or the number of management options that must be considered	14%	58%	28%
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	7%	72%	21%
Urgency of medical decision making	3%	90%	7%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	7%	66%	27%
Physical effort required	3%	85%	12%

Psychological Stress	Less	Identical	More
The risk of significant complications, morbidity and/or mortality	5%	71%	24%
Outcome depends on the skill and judgment of physician	2%	69%	29%
Estimated risk of malpractice suit with poor outcome	6%	73%	21%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	50%	50%	0%

Mental Effort and Judgment	Less	Identical	More
The number of possible diagnosis and/or the number of management options that must be considered	0%	65%	35%
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	4%	65%	31%
Urgency of medical decision making	4%	88%	8%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	69%	27%
Physical effort required	4%	92%	4%

Psychological Stress	Less	Identical	More
The risk of significant complications, morbidity and/or mortality	12%	42%	46%
Outcome depends on the skill and judgment of physician	4%	54%	42%
Estimated risk of malpractice suit with poor outcome	0%	81%	19%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an E/M service 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000. Code 64455 was identified on this list.

Survey Sample and Process

The survey request was sent to a random selection from the membership database for all participating societies. The American Academy of Orthopaedic Surgeons (AAOS), American Podiatric Medical Association (APMA), and American Orthopaedic Foot and Ankle Society (AOFAS) conducted a standard RUC survey and received 205 responses.

Pre-time Package 6

We recommend pre-time package 6, but have reduced the package evaluation time from 17 minutes to 5 minutes to account for overlap in time with an E/M service that is reported more than 50% of time. The recommended total pre-time of 11 minutes is consistent with the pre-time for key reference codes 64450 and 20550.

Key Reference Codes

The value for 64455 ranks appropriately relative to the key reference services. All three codes represent the same physician work.

MPC Comparison

MPC	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
67820	Correction of trichiasis; epilation, by forceps only	**0.71**	0.100	**15**	8	**5**	2
64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)	**0.75**	0.093	**21**	11	**5**	5
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	**0.84**	0.059	**22**	7	**10***	5

*When 12001 was reviewed in 2010, the intra-time included inject local anesthetic and wait for affect, which should have been included in the pre-time category.

Other Comparison Codes

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
20600	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); without ultrasound guidance	**0.66**	0.075	**21**	11	**5**	5
20605	Arthrocentesis, aspiration and/or injection, intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa); without ultrasound guidance	**0.68**	0.079	**21**	11	**5**	5
20612	Aspiration and/or injection of ganglion cyst(s) any location	**0.70**	0.073	**20**	10	**5**	5
65205	Removal of foreign body, external eye; conjunctival superficial	**0.71**	0.097	**15**	5	**5**	5
67820	Correction of trichiasis; epilation, by forceps only	**0.71**	0.100	**15**	8	**5**	2

CPT	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
64450	Injection, anesthetic agent; other peripheral nerve or branch	**0.75**	0.083	**20**	10	**5**	5
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	**0.75**	0.083	**21**	11	**5**	5
20551*	Injection(s); single tendon origin/insertion	**0.75**	0.083	**21**	11	**5**	5
64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)	**0.75**	0.083	**21**	11	**5**	5
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	**0.79**	0.101	**21**	11	**5**	5
64405	Injection, anesthetic agent; greater occipital nerve	**0.94**	0.112	**22**	7	**5**	10
67515	Injection of medication or other substance into Tenon's capsule	**1.40**	0.208	**21**	11	**5**	5
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	**1.44**	0.226	**22**	12	**5**	5
67500	Retrobulbar injection; medication (separate procedure, does not include supply of medication)	**1.44**	0.213	**25**	15	**5**	5

*Current recommendation for April 2017. See Tab 10.

Recommendation - 64455

We recommend maintaining the work RVU of 0.75 for 64455. This value is also the survey median and 25th percentile. The work to perform this procedure has not changed since this code was last reviewed (2008) and the survey data support this. This value maintains the RUC, specialty, and CMS accepted intensity/complexity rank order and relativity for code 64455 with many other injection codes and procedures requiring 5 minutes of intra-service time. This survey provides supporting evidence for the accuracy of the current relative work value for 64455.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Code 64455 may be reported with an E/M service with modifier 25 appended. Per CMS Medicare Claims Processing Manual (Chapter 12): Modifier 25 is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier "-25" to the appropriate level of evaluation and management service.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code

in your scenario. An office visit E/M code (99201-99205, 99211-99215) with modifer 25 appended may be reported when appropriate.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64455

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Orthopaedic surgery How often? Commonly

Specialty Podiatry How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. national frequency is not avaialable

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
65,979 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty.
Please explain the rationale for this estimate. RUC database

Specialty podiatry Frequency 61250 Percentage 92.83 %

Specialty orthopaedic surgery Frequency 2400 Percentage 3.63 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64455

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

ISSUE: Injection – Digital Nerves

TAB: 18

						RVW						PRE			INTRA					POS	SURVEY EXPERIENCE				
SOURCE	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Total Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	P-SD	MIN	25th	MED	75th	MAX
REF 1	64450	Injection, anesthetic agent; other peri	118	0.083			0.75			20	10					5			5					
REF 2	20550	Injection(s); single tendon sheath, or l	26	0.093			0.75			21	5	1	5			5			5					
current	64455	Injection(s), anesthetic agent and/or s		0.083			0.75			20	10					5			5					
SVY	64455	Injection(s), anesthetic agent and/or s	205	0.057	0.50	0.75	0.75	0.85	1.70	29	12	2	5	1	3	5	5	15	5	0	15	30	60	500
REC	64455			0.093			0.75			21	5	1	5			5			5					

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)

Global Period 000 Meeting Date: April 2017

*****N/A – no Facility Direct PE Inputs recommended*****

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

3. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

4. Please provide rationale for the minutes you are recommending for clinical activities that do not have PE Subcommittee standards:

5. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Spreadsheet Update Workgroup and listed in tab 2, please explain the difference here:

7. Please describe in detail the clinical activities of your staff below:

Pre-Service Period Clinical Activities:

Service Period Clinical Activities:

Pre-Service (of Service Period):

Intra-Service (of Service Period):

Post-Service (of Service Period):

Post-Service Period Clinical Activities:

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

9. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

16. If there is any other item on your spreadsheet that needs further explanation please include here:

REVISED 4-26-17

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's neuroma)

Global Period 000 Meeting Date: April 2017

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:
The society Advisors reviewed the current PE details and the PE details for the recently reviewed code 20550 to develop a recommendation for code 64455.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:
The current code and Key Ref code 20550 were used as references.

3. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:
N/A

4. Please provide rationale for the minutes you are recommending for clinical activities that do not have PE Subcommittee standards:

CA011 (provide education/obtain consent): Clinical staff will answer patient questions about the procedure and confirm that consent has been obtained and documented. This is consistent with the time approved by the PE Subcommittee and CMS for code 20550.

CA023 (monitor patient following procedure): Clinical staff will monitor the patient after the injection for any reaction to the medication or to having the injection.

5. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

SJ053 (swab-pad, alcohol): Item added - One pad to wipe the rubber septum of the anesthetic and one to wipe the rubber septum of the steroid. CDC guidelines for injectable medication preparation indicates that sterile technique includes disinfecting the rubber septum of a vial with alcohol prior to piercing it. Once an alcohol pad has been opened, handled, and used to clean contaminants from a vial septum, the pad is considered contaminated after used and is to be discarded.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Spreadsheet Update Workgroup and listed in tab 2, please explain the difference here: N/A

7. Please describe in detail the clinical activities of your staff below:

Pre-Service Period Clinical Activities: N/A

Service Period Clinical Activities:

Pre-Service (of Service Period): Clinical staff will provide pre-service education to reinforce the physician's description of the procedure. Consent for the procedure is confirmed and documented. The supplies necessary for the injections are collected so that the physician can prepare the syringes. This includes documenting the drug, lot number, and expiration of the injectants.

Intra-Service (of Service Period): Clinical staff will assist the physician during the injection for 100% of the physician's intra-service time. The injection will performed in a sterile fashion. The staff is available to hand the physician supplies as needed in a sterile fashion. This has not changed since the previous review in 2008. The clinical staff time was approved by the PE Subcommittee as 100% of assist physician time in 2008. AMA staff research indicates that there was an error in the final PE spreadsheet in 2008 submitted by the societies, where 3 minutes was indicated instead of 5 minutes.

Post-Service (of Service Period): The clinical staff will monitor the patient for post-injection reaction, check the injection site and review the physician's instructions with the patient about home care. Once the patient leaves the office, the procedure room is cleaned, including disposing of all supplies related to the injection and returning the injectants to secure storage.

Post-Service Period Clinical Activities: N/A

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*
Clinical staff assists the physician with maintaining patient positioning during the injection, hands supplies and syringes to the physician to maintain sterility, and is available to assist the physician as necessary.

9. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. N/A

10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: N/A

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. N/A

12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A

13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: N/A

14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: N/A

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: N/A

16. If there is any other item on your spreadsheet that needs further explanation please include here: N/A

	A	B	D	E	F	G	H	I	J	K
1	RUC Practice Expense Spreadsheet				RUC JAN-2016		RUC Apr 2008		RECOMMENDED	
2		*Please see brief summaries of the standards/guidelines in column			20550		64455		64455	
3		RUC Collaboration Website			Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")		Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's		Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's	
4	Clinical Activity Code	Meeting Date: April 2017 REVISED 4-28-17 Tab: 18 Specialty: APMA, AAOS, AOFAS	Clinical Staff Type Code	Clinical Staff Type						
5		LOCATION			Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD			000	000	000	000	000	000
7		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	17	0	19	0	19	0
8		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0	0	0	0	0	0
9		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	17	0	19	0	19	0
10		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0	0	0	0	0	0
11		PRE-SERVICE PERIOD								
12		Start: Following visit when decision for surgery or procedure made								
23		End: When patient enters office/facility for surgery/procedure								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**				**RUC JAN-2016**		**RUC Apr 2008**		**RECOMMENDED**	
2		***Please see brief summaries of the standards/guidelines in column***			**20550**		**64455**		**64455**	
3		***RUC Collaboration Website***			Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")		Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's		Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's	
4	**Clinical Activity Code**	**Meeting Date: April 2017 REVISED 4-28-17** **Tab: 18** **Specialty: APMA, AAOS, AOFAS**	**Clinical Staff Type Code**	**Clinical Staff Type**						
5		**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**			**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**17**	**0**	**19**	**0**	**19**	**0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**17**	**0**	**19**	**0**	**19**	**0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
24	**SERVICE PERIOD**									
25		**Start: When patient enters office/facility for surgery/procedure:**								
26		**Pre-Service (of service period)**								
27	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA						
28	CA010	Obtain vital signs	L037D	RN/LPN/MTA						
29	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	3		3		3	
31	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	3		2		**2**	
34	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA			2			
38		**Intra-service (of service period)**								
39	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100% of physician intra-service time)	L037D	RN/LPN/MTA	5		**3**		5	

	A	B	D	E	F	G	H	I	J	K
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2		***Please see brief summaries of the standards/guidelines in column***			**20550**		**64455**		**64455**	
3		***RUC Collaboration Website***			Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")		Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's		Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's	
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5		**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**			**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**17**	**0**	**19**	**0**	**19**	**0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**17**	**0**	**19**	**0**	**19**	**0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
44		**Post-Service (of service period)**								
46	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	3		3		3	
47	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA			3		3	
52	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	1		1		1	
58	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	2		2		2	
62		**End: Patient leaves office**								

	A	B	D	E	F	G	H	I	J	K
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3		RUC Collaboration Website			Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")		Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's		Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's	
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6		GLOBAL PERIOD			000	000	000	000	000	000
7		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	17	0	19	0	19	0
8		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0	0	0	0	0	0
9		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	17	0	19	0	19	0
10		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0	0	0	0	0	0
63		POST-SERVICE PERIOD								
64		Start: Patient leaves office/facility								
76		End: with last office visit before end of global period								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**				**RUC JAN-2016**		**RUC Apr 2008**		**RECOMMENDED**	
2		***Please see brief summaries of the standards/guidelines in column***			**20550**		**64455**		**64455**	
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5		**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**			**000**	**000**	**000**	**000**	**000**	**000**
7		**TOTAL CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**17**	**0**	**19**	**0**	**19**	**0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**17**	**0**	**19**	**0**	**19**	**0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**0**	**0**	**0**	**0**	**0**	**0**
77	**Medical Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
78	SA048	pack, minimum multi-specialty visit	1.143	pack						
79	SB007	drape, sterile barrier 16in x 29in	0.494	item	1		1		1	
80	SB024	gloves, sterile	0.84	pair	1		1		1	
81	SJ041	povidone soln (Betadine)	0.008	ml	10		10		10	
82	SJ053	swab-pad, alcohol	0.013	item			2		2	
83	SH047	lidocaine 1%-2% inj (Xylocaine)	0.035	ml	2		2		2	
84	SC029	needle, 18-27g	0.089	item	2		2		2	
85	SC051	syringe 10-12ml	0.184	item	1		1		1	
86	SG056	gauze, sterile 4in x 4in (10 pack uou)	0.798	item	1		1		1	
87	SG021	bandage, strip 0.75in x 3in (Bandaid)	0.043	item	1		1		1	
89	**Equipment Code**	**EQUIPMENT**	**PRICE**	**EQUIPMENT FORMULA**						
90	EF023	table, exam	1338.17	Non-highly Technical Equipment Formula	17		19		19	
91	EQ168	light, exam	1630.12	Non-highly Technical Equipment Formula	17		19		0	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2018

Somatic Nerve Injection

In May 2018 the CPT Editorial Panel approved the revision of descriptors and guidelines for codes 64400- 64450 and deletion of 3 codes to clarify reporting (ie, separate reporting of imaging guidance, number of units, change of CPT codes 64421 from a 0-day global to ZZZ). Codes 64400-64450 describe the injection of an anesthetic agent(s) and/or steroid into a nerve plexus, nerve, or branch. These codes are reported once per nerve plexus, nerve, or branch as described in the descriptor regardless of the number of injections performed along the nerve plexus, nerve, or branch described by the code. Image guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately. The physician work for this family of services varies based on the anatomic location of each nerve, whether the services is typically performed in the facility setting, the typical approach used by the dominant specialty to access the nerve that performs each service and whether the service involves continuous infusion by catheter.

64400 ***Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)***
The RUC reviewed the survey results from 56 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 1 minute of pre-service positioning, 1 minute of pre-service scrub/dress/wait, 6 minutes of intra-service time and 5 minutes of immediate post-service time. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison. The IWPUT for the current times is similar to scrub/dress/wait IWPUT, which strongly implies the current times are highly inflated relative to the current work RVU and not valid for comparison to the new times.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.14. To find an appropriate work RVU, the RUC reviewed the survey 25th percentile for only the neurologist survey respondents of 1.00, noting that neurology is the top performing specialty yet there were fewer survey responses from neurology than from anesthesiology. Neurology is 47 percent of the 2017 Medicare claims whereas anesthesiology is only 10 percent of the claims, the RUC noted that it would be appropriate to value the service at the Neurology 25th percentile of 1.00. To justify a work RVU of 1.00, the RUC compared the survey code to CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.94, intra-service time of 5 minutes) and noted that the reference code more intra-service time and involves slightly more physician work. The RUC also compared the survey code to MPC code 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* **(**work RVU = 1.00, intra-service time of 7 minutes, total time of 17 minutes) and noted that although the survey code has 1 minute less of intra-service time, it has 3 more minutes of total time and both services involve a similar amount of physician work. **The RUC recommends a work RVU of 1.00 for CPT code 64400.**

64408 ***Injection(s), anesthetic agent(s) and/or steroid; vagus nerve***
The RUC reviewed the survey results from 37 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 0.90. To justify a work RVU of 0.90, the RUC compared the survey code to CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.94, intra-service time of 5 minutes) and noted that both services have identical intra-service times and involve a similar amount of physician work, and therefore should be valued similarly. The RUC also compared the survey code to MPC code 36620 *Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous* **(**work RVU = 1.00, intra-service time of 7 minutes, total time of 17 minutes) and noted that the survey code involves 2 minutes less of intra-service time and it would be appropriate to value the survey code somewhat less as it involves somewhat less overall work. **The RUC recommends a work RVU of 0.90 for CPT code 64408.**

64415 ***Injection(s), anesthetic agent(s) and/or steroid; brachial plexus***
The RUC reviewed the survey results from 57 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 4 minutes of pre-service scrub/dress/wait, 12 minutes of intra-service time and 10 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 1.42. To justify a work RVU of 1.42, the RUC compared the survey code to CPT code 64612 *Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)* (work RVU = 1.41, intra-service time of 10 minutes) and noted that the survey code involves slightly more intra-service time and slightly less total time and both services include a similar amount of physician work. The RUC also compared the survey code to CPT code 30903 *Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method* (work RVU = 1.54, intra-service time of 15 minutes, total time of 39 minutes) and noted that the survey code involves less intra-service time and valuing the survey code at 1.42 would maintain appropriate relativity with the reference code. **The RUC recommends a work RVU of 1.42 for CPT code 64415.**

64416 ***Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)***
The RUC reviewed the survey results from 42 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 20 minutes of intra-service time and 10 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 1.81 To justify a work RVU of 1.81, the RUC compared the survey

code to CPT code 32554 *Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance* (work RVU = 1.82, intra-service time of 20 minutes) and noted that both services involve identical intra-service time and have typically require a similar amount of physician work. **The RUC recommends a work RVU of 1.81 for CPT code 64416.**

64417 ***Injection(s), anesthetic agent(s) and/or steroid; axillary nerve***
The RUC reviewed the survey results from 45 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 4 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 10 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 1.27. To justify a work RVU of 1.27, the RUC compared the survey code to CPT code 49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance* (work RVU = 1.24, intra-service time of 10 minutes) and noted that both services involve identical intra-service time and total time and a similar amount of physician work. The RUC also compared the code to CPT code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24, intra-service time of 10) and noted that both services have identical intra-service times and involve a similar amount of physician work. The RUC noted that 64417 has appropriate relativity with the rest of the family. For example, 64415 and 64417 involve a similar work intensity and therefore the RUC recommendations for both services have similar IWPUTs. **The RUC recommends a work RVU of 1.27 for CPT code 64417.**

64420 ***Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level***
The RUC reviewed the survey results from 60 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 5 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting. The RUC noted that the current times for this service are from the Harvard study more than 20 years ago; in 1994, the RVU for this service was lowered substantially but the intra-service time was not changed to reflect the decrease. Therefore, a reduction in time would not necessarily imply a reduction in work value as the previous times used a flawed methodology.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.24. The RUC also reviewed the current value for this service of 1.18 and noted that would continue to be the appropriate value for this service. To verify a value of 1.18, the RUC compared the survey code to CPT code 49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance* (work RVU = 1.24, intra-service time of 10 minutes) and noted that both codes involve identical intra-service time, whereas the reference code involves somewhat more total time and that the survey code should be valued somewhat lower. The RUC also compared the code to CPT code 32562 *Instillation(s), via chest tube/catheter, agent for*

fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day (work RVU = 1.24, intra-service time of 10) and noted that both services have identical intra-service times and involve a similar amount of physician work. The RUC noted that 64417 has appropriate relativity with the rest of the family. For example, 64420 and 64417 involve a similar work intensity and therefore the RUC recommendations for both services have similar IWPUTs. **The RUC recommends a work RVU of 1.18 for CPT code 64420.**

64421 ***Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, each additional level (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 60 physicians and agreed on the following physician time components: 10 minutes of intra-service time. The RUC noted that the coding structure for 64421 changed when the code was revised by CPT; 64421 switched from a 000-day global code that code only be reported a single time to an add-on code for 64420. Furthermore, the current physician times for 64421 are over 25 years old and from the Harvard study.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.00. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 77063 *Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)* (work RVU = 0.60, intra-service time of 8 minutes) and noted that although the survey code involves somewhat more intra-service time, both services require a very similar amount of physician work. Therefore, the RUC recommends a direct work RVU crosswalk from 77063 to 64421. **The RUC recommends a work RVU of 0.60 for CPT code 64421.**

64425 ***Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves***
The RUC reviewed the survey results from 54 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 1 minute of pre-service positioning, 1 minute of pre-service scrub/dress/wait, 11 minutes of intra-service time and 5 minutes of immediate post-service time. The RUC noted that the current times for this service are over 25 years old from the Harvard study and not valid for comparison.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 1.19. To justify a work RVU of 1.19, the RUC compared the survey code to CPT code 49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance* (work RVU = 1.24, intra-service time of 10 minutes) and noted that both services involve identical intra-service time and whereas the reference code involves somewhat more total time and it would be appropriate to value the survey code somewhat lower than the reference code at a value of 1.19. The RUC also compared the code to CPT code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24, intra-service time of 10) and noted that both services have similar intra-service times and the survey code should be valued slightly less than the reference code to maintain appropriate relativity. **The RUC recommends a work RVU of 1.19 for CPT code 64425.**

64430 ***Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve***
The RUC reviewed the survey results from 67 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 5 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 10 minutes of immediate post-service time. The specialty noted and the RUC agreed that this service requires more post-time than CPT code 64425 as the pudendal nerve is deeper. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting. The post-service time is longer for 64430 compared to 64435 because the approach involves going much deeper and the physician typically stays longer as the patient tends to have pelvic muscle weakness. Unlike for 64435, for 64430, the patient is then re-examined digitally to confirm pelvic stability and pelvic floor tonicity during the post-service period. The patient is then evaluated for safety in ambulation.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 1.15. To justify a work RVU of 1.15, the RUC compared the survey code to CPT code 49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance* (work RVU = 1.24, intra-service time of 10 minutes) and noted that both services involve identical intra-service time and whereas the reference code involves somewhat more total time and it would be appropriate to value the survey code somewhat lower than the reference code at a value of 1.15. The RUC also compared the code to CPT code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24, intra-service time of 10) and noted that both services have identical intra-service times and the survey code should be valued slightly less than the reference code to maintain appropriate relativity. **The RUC recommends a work RVU of 1.15 for CPT code 64430.**

64435 ***Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve***
The RUC reviewed the survey results from 42 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 3 minutes of pre-service positioning, 5 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents appropriately valued the physician work involved in performing this service at the 25th percentile work RVU of 0.75. To justify a work RVU of 0.75, the RUC compared the survey code to top key reference code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75, intra-service time of 5, total time of 20 minutes) and noted that both services involve identical intra-service time and total time and the same amount of physician work. The RUC also compared the survey code to CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.94, intra-service time of 5 minutes) and noted that although both services have identical intra-service time, the reference code involves more total time, justifying a somewhat lower valuation for the survey code. **The RUC recommends a work RVU of 0.75 for CPT code 64435.**

64445 ***Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve***
The RUC reviewed the survey results from 68 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 1 minutes of pre-service positioning, 1 minutes of pre-service scrub/dress/wait, 10 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.30. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 67810 *Incisional biopsy of eyelid skin including lid margin* (work RVU = 1.18, intra-service time of 13 minutes, total time of 27 minutes and noted that although the survey code involves somewhat less intra-service time, it involves somewhat more total time and a very similar amount of physician work. The RUC recommends a direct work RVU crosswalk from CPT code 67810 to CPT code 64445. The RUC also compared the code to CPT code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24, intra-service time of 10) and noted that both services have identical intra-service times and whereas the survey code involves slightly more overall physician work. **The RUC recommends a work RVU of 1.18 for CPT code 64445.**

64446 ***Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)***
The RUC reviewed the survey results from 48 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 15 minutes of intra-service time and 6 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.80. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 30903 *Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method* (work RVU = 1.54, intra-service time of 15 minutes, total time of 39 minutes) and noted that both services have identical intra-service time and total time and involve an identical amount of physician work. The RUC recommends a direct work RVU crosswalk from CPT code 30903 to CPT code 64446. **The RUC recommends a work RVU of 1.54 for CPT code 64446.**

64447 ***Injection(s), anesthetic agent(s) and/or steroid; femoral nerve***
The RUC reviewed the survey results from 62 physicians and agreed on the following physician time components: 12 minutes of pre-service evaluation, 1 minute of pre-service positioning, 3 minutes of pre-service scrub/dress/wait, 6 minutes of intra-service time and 5 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.29. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)* (work RVU = 1.10, intra-service time of 7 minutes, total time of 21 minutes) and noted that although the survey code involves slightly less intra-service time, it requires more total time and a very similar amount of physician work. The RUC recommends a direct work RVU crosswalk from CPT code 31231 to CPT code 64447. **The RUC recommends a work RVU of 1.10 for CPT code 64447.**

64448 ***Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)***
The RUC reviewed the survey results from 51 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minute of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 13 minutes of intra-service time and 6 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.78. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 62322 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance* (work RVU = 1.55, intra-service time of 11 minutes, total time of 39 minutes) and noted that the survey code involves somewhat more intra-service time whereas both services only differ on total time by 1 minute and require a very similar total amount of physician work. The RUC recommends a direct work RVU crosswalk from CPT code 62322 to CPT code 64448. The RUC also compared the survey code to MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina;* (work RVU = 1.50, intra-service time of 15 minutes, total time of 40 minutes) and noted that both services involve similar intra-service time and total time and should be valued similarly. **The RUC recommends a work RVU of 1.55 for CPT code 64448.**

64449 ***Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)***
The RUC reviewed the survey results from 36 physicians and agreed on the following physician time components: 13 minutes of pre-service evaluation, 1 minutes of pre-service positioning, 5 minutes of pre-service scrub/dress/wait, 14 minutes of intra-service time and 5 minutes of immediate post-service time. This service is typically performed in the facility setting and requires more pre-service evaluation and scrub/dress/wait time than services in this family that are typically performed in the non-facility setting.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.80. To find an appropriate work RVU crosswalk, the RUC compared the survey code to CPT code 62322 *Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance* (work RVU = 1.55, intra-service time of 11 minutes, total time of 39 minutes) and noted that the survey code involves somewhat more intra-service time whereas both services only differ on total time by 1 minute and require a very similar total amount of physician work. The RUC recommends a direct work RVU crosswalk from CPT code 62322 to CPT code 64449. The RUC also compared the survey code to MPC code 57452 *Colposcopy of the cervix including upper/adjacent vagina;* (work RVU = 1.50, intra-service time of 15 minutes, total time of 40 minutes) and noted that both services involve similar intra-service time and total time and should be valued similarly. The RUC noted that survey codes 64448 and 64449 have identical total times, only one minute difference in intra-service time and involve the same amount of physician work. **The RUC recommends a work RVU of 1.55 for CPT code 64449.**

64450 ***Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch***
The RUC reviewed the survey results from 88 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 1 minute of pre-service positioning, 1 minute of pre-service scrub/dress/wait, 5 minutes of intra-service time and 5 minutes of immediate post-service time.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the respondents somewhat overvalued the work involved in performing this service, with a 25th percentile work RVU of 1.00. The RUC also reviewed the current value for this service of 0.75 and noted that would continue to be the appropriate value for this service. To justify a work RVU of 0.75, the RUC compared the survey code to CPT code 20551 *Injection(s); single tendon origin/insertion* (work RVU = 0.75, intra-service time of 5, total time of 20 minutes) and noted that both services involve identical intra-service time and very similar total time and the same amount of physician work. The RUC also compared the survey code to CPT code 31575 *Laryngoscopy, flexible; diagnostic* (work RVU = 0.94, intra-service time of 5 minutes) and noted that although both services have identical intra-service time, the reference code involves more total time and somewhat more intensity, justifying a somewhat lower valuation for the survey code. **The RUC recommends a work RVU of 0.75 for CPT code 64450.**

RUC Referral to CPT
During the October 2018 RUC presentation for this family of services, the specialty societies stated that codes 64415, 64416, 64417, 64446, 66447, and 64448 were reported with code 76942 *Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device), imaging supervision and interpretation* more than 50 percent of the time. Specifically, 76 percent with 64415, 85 percent with 64416, 68 percent with 64417, 77 percent with 64446, 77 percent with 66447, and 79 percent with 64448. The societies indicated they would submit a code change application to bundle 76942 into codes 64415, 64416, 64417, 64446, 64447, and 64448 for the 2021 cycle. This overlap was accounted for in the above RUC recommendations for these services. **The RUC refers CPT codes 64415, 64416, 64417, 64446, 64447 and 64448 to be bundled with ultrasound guidance, CPT code 76942 to the CPT Editorial Panel for CPT 2021.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs as approved by the Practice Expense Subcommittee, with the only revision to account for the reduction in procedure time for codes 64400 and 64450.

Work Neutrality
The RUC's recommendation for these codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendations for CPT codes 64405 (work RVU= 0.94, pre-evaluation time of 5 minutes, pre-positioning time of 1 minute, intra-service time of 5 minutes and post-service time of 5 minutes) and 64418 (work RVU= 1.10, pre-evaluation time of 6

minutes, pre-positioning time of 3 minutes, pre-scrub/dress/wait time of 3 minutes, intra-service time of 10 minutes, post-service time of 10 minutes). The relativity within the family remains correct.

Do Not Use to Validate for Physician Work
The RUC agreed that CPT codes 64400 and 64418 should be labeled in the RUC database with a flag that it should not be used to validate physician work.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Nervous System **Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System** **Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic** *(For destruction by neurolytic agent or chemodenervation, see 62280-62282, 64600-64681)* *(For epidural or subarachnoid injection, see 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327)* *(*64400-64455, 64461, 64462, 64463, 64479, 64480, 64483, 64484~~7~~*,* 64490-64495 are unilateral procedures. For bilateral procedures, use modifier 50) **Somatic Nerves** Codes 64400-64489 describe the introduction/injection of an anesthetic agent and/or steroid into the somatic nervous system for diagnostic or therapeutic purposes. For injection or destruction of genicular nerve branches, see 644X0, 644X1. Codes 64400-64450, 644X0 describe the injection of an anesthetic agent(s) and/or steroid into a nerve plexus, nerve, or branch. These codes are reported once per nerve plexus, nerve, or branch as described in the descriptor regardless of the number of injections performed along the nerve plexus, nerve, or branch described by the code. Image guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately.				

Image guidance (ultrasound, fluoroscopy, CT) and any injection of contrast are inclusive components of 644X0.

Codes 64455, 64479, 64480, 64483, 64484 are reported for ~~a~~ single or multiple injections at the same site. For 64479, 64480, 64483, 64484, image guidance (fluoroscopy or CT) and any injection of contrast are inclusive components and are not reported separately. For 64455, image guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately.

Codes 64461, 64462, 64463 describe injection of a paravertebral block (PVB). Codes 64486, 64487, 64488, 64489 describe injection of a transversus abdominis plane (TAP) block. Image guidance and any injection of contrast are inclusive components of 64461, 64462, 64463 and 64486, 64487, 64488, 64489 and are not reported separately.

▲64400	H1	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each ~~any division or~~ branch (ie, ophthalmic, maxillary, mandibular)	000	1.00
~~D~~64402	-	~~facial nerve~~ (64402 has been deleted. To report injection of anesthetic agent and/or steroid to the facial nerve, use 64999)	000	N/A (2018 work RVU = 1.25)
▲64405	H2	greater occipital nerve	000	0.94 (Affirmed April 2017 RUC Recommendation)
▲64408	H3	vagus nerve	000	0.90
~~D~~64410	-	~~phrenic nerve~~ *(64412 has been deleted. To report, use 64999)*	000	N/A (2018 work RVU = 1.43)
~~D~~64413	-	~~cervical plexus~~ (64410, 64413 have been deleted. To report injection of anesthetic agent and/or steroid to the phrenic nerve, cervical plexus, use 64999)	000	N/A (2018 work RVU = 1.40)

▲64415	H4	brachial plexus~~, single~~	000	1.42
▲64416	H5	brachial plexus, continuous infusion by catheter (including catheter placement) *(Do not report 64416 in conjunction with 01996)*	000	1.81
▲64417	H6	axillary nerve	000	1.27
▲64418	H7	suprascapular nerve	000	1.10 (Affirmed April 2016 RUC Recommendation)
▲64420	H8	intercostal nerve, single level	000	1.18
✚▲64421	H9	intercostal nerve~~s~~, ~~multiple,~~ ~~regional block,~~ each additional level (List separately in addition to code for primary procedure) (Use 64421 in conjunction with 64420)	~~000~~ ZZZ	0.60
▲64425	H10	ilioinguinal, iliohypogastric nerves	000	1.19
▲ 64430	H11	pudendal nerve	000	1.15
▲64435	H12	paracervical (uterine) nerve	000	0.75

▲64445	H13	sciatic nerve~~, single~~	000	1.18
▲64446	H14	sciatic nerve, continuous infusion by catheter (including catheter placement) *(Do not report 64446 in conjunction with 01996)*	000	1.54
▲64447	H15	femoral nerve~~, single~~ *(Do not report 64447 in conjunction with 01996)*	000	1.10
▲64448	H16	femoral nerve, continuous infusion by catheter (including catheter placement) *(Do not report 64448 in conjunction with 01996)*	000	1.55
▲64449	H17	lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) *(Do not report 64449 in conjunction with 01996)*	000	1.55
▲64450	H18	other peripheral nerve or branch	000	0.75

Codes	Unit Per Code	Image Guidance
64400-64450	1 unit per plexus, nerve, or branch injected regardless of the number of injections	Reported separately, when performed
64XX1	1 unit for any number of genicular nerve branches, with a required minimum of three nerve branches	Included, when performed
64455	1 or more injections per code	Reported separately, when performed
64479, ✚64480, 64483, ✚64484	1 or more injections per level	Included, when performed
64461, ✚64462, 64463	By injection site	Included, when performed
64486-64489	By block	Included, when performed

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System			
Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic atic Nerve			
Code(s)	**Unit**	**Image Guidance Included**	**Image Guidance Separately reported, when performed**
Somatic Nerve			
64400-64450	1 unit per plexus, nerve, or branch injected regardless of the number of injections		**X**
64455	1 or more injections per code		**X**
64479	1 or more injections per code	**X**	
+64480	1 or more injections per code (add-on)	**X**	
64483	1 or more injections per code	**X**	
+64484	1 or more injections per code (add-on)	**X**	
64461	1 or more injections per level	**X**	
+64462	1 or more injections per code (add-on)	**X**	
64463	1 or more injections per code	**X**	
64486-64489	By injection site	**X**	
64XX0	1 unit for any number of genicular nerve branches, with a required minimum of three nerve branches		**X**

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June 1, 2018

Peter K. Smith, MD, Chair
AMA/RVS Update Committee (RUC)
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

Re: Somatic Nerve Procedures

Dear Dr. Smith:

At its recent May 2018 meeting, the CPT Editorial panel approved new guidelines for the Somatic Nerve code family as well as minor edits to the code language for 64400-64450. Included within the code family are two codes that were recently reviewed by the RUC:

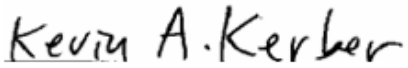
- 64405 Injection(s), anesthetic agent(s) and/or steroid; greater occipital nerve – RUC reviewed April 2017, values will go into effect January 2019.
- 64418 Injection(s), anesthetic agent(s) and or steroid; suprascapular nerve – RUC reviewed April 2016.

While these codes underwent minor editorial changes, there has been no change in the physician work for these two codes since they were last surveyed. We do not believe a re-survey of these codes is necessary. The joint societies therefore recommend that the current RUC values and inputs for codes 64405 (0.94 work RVU) and 64418 (1.10 work RVU) be re-affirmed at the October 2018 RUC meeting.

We look forward to presenting our recommendations for the Somatic Nerve code family at the upcoming RUC meeting. Please contact AAPM&R staff Carolyn Winter-Rosenberg at (847) 737-6024 or via email at cwinterrosenberg@aapmr.org if you have any questions.

Thank you for your consideration of this request.

Sincerely,



Kevin A. Kerber, MD
AAN RUC Advisor

Matthew Grierson, MD
AAPM&R RUC Advisor

Richard W. Rosenquist, MD
ASA RUC Advisor

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64400 Tracking Number Original Specialty Recommended RVU: **1.14**
Presented Recommended RVU: **1.10**
Global Period: 000 Current Work RVU: **1.11** RUC Recommended RVU: **1.00**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with a normal neurologic exam reports headaches that include pain in one or more branches of the trigeminal nerve (ophthalmic, maxillary, or mandibular). An injection of local anesthetic with or without a steroid is performed for nerve blockade.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The provider prepares the skin with an antiseptic solution, applies sterile drapes and then performs the universal protocol (“time out”) with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the procedure area are identified. A local anesthetic wheal is created and placed at the site of the injection. The provider penetrates the skin with the needle and injects the contents of the syringe along the course of the supraorbital nerve near the medial border of the eyebrow around the supraorbital notch. The needle is removed and the site is observed for bleeding and then covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and evidence of a successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Kevin Kerber, MD (AAN); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA); Raissa Villanueva, MD (AAN)				
Specialty Society(ies):	American Academy of Neurology; American Society of Anesthesiologists				
CPT Code:	64400				
Sample Size:	7147	**Resp N:**	56	**Response:** 0.7 %	
Description of Sample:	random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**10.00**	50.00	500.00
Survey RVW:	0.50	1.14	**1.50**	2.20	15.00
Pre-Service Evaluation Time:			**18.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	5.00	**15.00**	20.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64400	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**1.00**	**1.00**	**0.00**
Intra-Service Time:		**6.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x 0.00 99292x 0.00
Other Hospital time/visit(s):	0.00	99231x 0.00 99232x 0.00 99233x 0.00
Discharge Day Mgmt:	0.00	99238x 0.0 99239x 0.0 99217x 0.00
Office time/visit(s):	0.00	99211x 0.00 12x 0.00 13x 0.00 14x 0.00 15x 0.00
Prolonged Services:	0.00	99354x 0.00 55x 0.00 56x 0.00 57x 0.00
Sub Obs Care:	0.00	99224x 0.00 99225x 0.00 99226x 0.00

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62325	000	2.20	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64644	000	1.82	**RUC Time**

CPT Descriptor Chemodenervation of one extremity; 5 or more muscles

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36620	000	1.00	**RUC Time**	577,293

CPT Descriptor 1 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	1.75	**RUC Time**	450,710

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

Other Reference CPT Code	Global	Work RVU	Time Source
12002	000	1.14	**RUC Time**

CPT Descriptor Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 11 **% of respondents:** 19.6 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 14.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 64400	Top Key Reference CPT Code: 62325	2nd Key Reference CPT Code: **64644**
Median Pre-Service Time	9.00	20.00	15.00
Median Intra-Service Time	6.00	15.00	25.00
Median Immediate Post-service Time	5.00	10.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**45.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	0%	64%	36%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	18%	82%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	9%	91%
Physical effort required	0%	70%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	18%	36%	45%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	13%	0%	50%	38%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	38%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	25%	75%
Physical effort required	0%	57%	43%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	13%	75%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64400 (*Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use

of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64400, is currently a Harvard-valued code that has not been previously surveyed. It is a 0-day global code. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA) and the American Academy of Neurology (AAN).

October 2018 RUC Meeting Recommendation Rationale

A total of 56 responses were received from a random sample of 7,147 clinicians (0.7 percent response rate). ASA and AAN convened an Expert Panel to review the survey data. ***The societies are recommending 1.10 wRVUs and time of pre (7/1/1), intra (15 min) and post (10 min)***. This results in an IWPUT of 0.046.

Vignette

The typical patient for code 64400 presents with a normal neurologic exam but reports headaches that include pain in one or more branches of the trigeminal nerve (ophthalmic, maxillary, or mandibular). An injection of local anesthetic with or without a steroid is performed for nerve blockade. 95% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64400 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.14	1.50	2.20
Pre		18/5/5	
Intra	5	15	20
Post		10	

After review of the reviewer comments of the societies original recommended wRVU of 1.14 and time inputs, the Expert Panel agreed to recommend the following revised work RVU and time recommendation:

- wRVU
  - 1.10 wRVUs; this value is less than the 25th percentile
- Time
  - Pre-time: Non-facility pre-service package #5 with an additional minute for positioning (7/1/1)
  - Intra-time: 15 minutes (survey median)
  - Post-time 10 minutes (survey median)

Crosswalk

The Expert Panel agreed to recommend as a value: 1.10 wRVU. The Expert Panel is basing its recommendation on a crosswalk to code **56605** (*Biopsy of vulva or perineum (separate procedure); 1 lesion*); with wRVU 1.10, with times 10/15/10 with resultant IWPUT 0.0435.

The Expert Panel also noted that the recommended value aligned with other reference code **12002** (*Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm*)); with wRVU 1.14, with times 7/15/5 with resultant IWPUT 0.0590.

Current Value

- The current value of code 64400 is 1.11 wRVU
- The recommended wRVU of 1.10 is virtually and effectively identical

Comparison to Other Codes

The Expert Panel compared the recommendation for 64400 to other codes and identified other 0-day global codes with similar intra-time. These comparisons indicated the code was well aligned with other codes of similar time and value.

CPT Code	Long Desc	Global	Work RVU	Intra Time	IWPUT	2017 Utilization

CPT Code	Long Desc	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
46614	Anoscopy; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)	000	1.00	15	0.0338	887
11042	Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less	000	1.01	15	0.0369	1,816,207
45335	Sigmoidoscopy, flexible; with directed submucosal injection(s), any substance	000	1.04	15	0.0263	3,140
50431	Injection procedure for antegrade nephrostogram and/or ureterogram, complete diagnostic procedure including imaging guidance (eg, ultrasound and fluoroscopy) and all associated radiological supervision and interpretation; existing access	000	1.10	15	0.0193	9,546
56605	Biopsy of vulva or perineum (separate procedure); 1 lesion	000	1.10	15	0.0435	30,749
64400	**Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)**	**0**	**1.10**	**15**	**0.046**	**33,977**
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	000	1.14	15	0.059	146,808
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	000	1.14	15	0.0345	36,331
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	000	1.2	15	0.04	5,630
44385	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	1.2	15	0.037	1,359
57100	Biopsy of vaginal mucosa; simple (separate procedure)	000	1.2	15	0.0427	5,797
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	000	1.2	15	0.06	7,650
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	000	1.22	15	0.0644	50,886
40490	Biopsy of lip	000	1.22	15	0.0577	34,141

In summary, for CPT code 64400 (*Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular*) ***ASA and AAN recommend 1.10 wRVUs and 9/15/10 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64400

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty Anesthesiology How often? Commonly

Specialty Nurse Practitioners How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 101931
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Neurology Frequency 47541 Percentage 46.64 %

Specialty Anesthesiology Frequency 9928 Percentage 9.73 %

Specialty Nurse Practitioners Frequency 6891 Percentage 6.76 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 33,977 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization data

Specialty Neurology Frequency 15847 Percentage 46.64 %

Specialty Anesthesiology Frequency 3309 Percentage 9.73 %

Specialty Nurse Practitioners Frequency 2297 Percentage 6.76 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64400

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64408 Tracking Number

Original Specialty Recommended RVU: **0.94**
Presented Recommended RVU: **0.90**
RUC Recommended RVU: **0.90**

Global Period: 000 Current Work RVU: **1.41**

CPT Descriptor: Injection, anesthetic agent; vagus nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female presents with a neurogenic cough. Injection of an anesthetic agent to the vagus nerve is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review history and physical findings, including prior tests. Discuss procedure with patient, and obtain informed consent. Ensure that necessary equipment is available and set up. After confirming correct injectant, remove disposable top from vial and clean medication top; then draw injectant. After patient is again examined and appropriate central and lateral neck landmarks are palpated, perform a time out; position patient in a partially recumbent position with head turned and neck extended; and place a shoulder roll if needed. Prep the neck using alcohol swabs.

Description of Intra-Service Work: Palpate the lateral neck landmarks. Guide spinal needle into paralaryngeal area. After aspiration for blood and air is performed to insure extraluminal and extravascular position, deliver the injectant solution. Remove injection needle then apply pressure to the injection site if needed to stop bleeding. Inspect the neck for signs of hematoma or other complications.

Description of Post-Service Work: Apply bandage. Return patient to sitting position. Observe the patient post-procedure for, any hemodynamic changes, new, unexpected neurologic deficits, vascular injury, or airway compromise. The physician communicates observation instructions with the nursing staff, patient, family, and other professionals (including written and telephone reports and orders). Document the procedure in the medical record, providing a detailed description of the placement of the injection and the patient's responses. After an appropriate period of monitoring for hemodynamic stability, mental orientation, and the neurovascular status of neck, reexamine the patient to confirm successful injection and adequate response. If the patient is stable, discharge her or him home after meeting all appropriate discharge criteria. Prior to discharge, remind the patient and family of signs and symptoms of potential complications, provide contact information to be used if such signs or symptoms develop, and discuss and arrange appropriate follow up.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	09/2018		
Presenter(s):	Peter Manes, MD, Jay Shah, MD, Lance Manning, MD		
Specialty Society(ies):	AAO-HNS		
CPT Code:	64408		
Sample Size:	582	**Resp N:** 37	**Response:** 6.3 %
Description of Sample:	Targeted Random - Surveyed all Laryngologists in our membership		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	15.00	100.00
Survey RVW:	0.75	0.90	**1.25**	1.90	11.00
Pre-Service Evaluation Time:			**21.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**2.00**		
Intra-Service Time:	2.00	3.00	**5.00**	10.00	45.00

Immediate Post Service-Time:	**6.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64408	**Recommended Physician Work RVU: 0.90**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**0.00**	**3.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**1.00**	**-1.00**
Intra-Service Time:		**5.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
20552	000	0.66	**RUC Time**

CPT Descriptor Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20552	000	0.66	**RUC Time**	371,780

CPT Descriptor 1 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64644	000	1.82	**RUC Time**	31,712

CPT Descriptor 2 Chemodenervation of one extremity; 5 or more muscles

Other Reference CPT Code	Global	Work RVU	Time Source
64405	000	0.94	**RUC Time**

CPT Descriptor Injection, anesthetic agent; greater occipital nerve

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 7 **% of respondents:** 18.9 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 13.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 64408	Top Key Reference CPT Code: 20552	2nd Key Reference CPT Code: **64486**
Median Pre-Service Time	10.00	11.00	15.00
Median Intra-Service Time	5.00	5.00	10.00
Median Immediate Post-service Time	5.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**21.00**	**35.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	14%	57%	29%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	14%	86%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	99%
Physical effort required	0%	71%	29%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	43%	57%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	60%	40%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	40%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	40%	60%
Physical effort required	40%	40%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	40%	60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Why is this code being reviewed?

A code change proposal was brought before the CPT Editorial Panel in May 2018 requesting modifications to the Somantic Nerve Injection family of codes. This included 64408. The entire family was then referred for survey at the September 2018 RUC meeting. No other specialties indicated an interest in this code, and Otolaryngology as the dominant user of the service elected to survey it. No changes were made at CPT to this CPT code.

Description of Random Survey Sample

Our physician work RVU recommendation was derived by conducting a targeted random survey of AAO-HNS members with a designation of laryngology in our database. The standard 000 global survey instrument was utilized. Surveys were sent to 568 Otolaryngologists. We received 37 responses.

Physician Time

Pre-Time

Regarding physician time, we recommend using pre-service package 5 Procedure with minimal anesthesia care which includes 7 minutes of evaluation, 0 minutes of positioning, and 1 minutes of scrub, dress, and wait time. Our expert panel felt this package was most appropriate given that this procedure does not utilize local anesthesia.

Evaluation time: Our experts felt that the 21 minutes of evaluation time provided by respondents was excessive given the short overall time for the procedure, therefore, we reduced this down to the package's recommended 7 minutes of evaluation time.

Positioning time: Regarding time for positioning, our expert panel reviewed the 0 minutes of time assigned by package 5 and felt this was insufficient for this particular procedure. Time must be taken to position the patient, using the headrest in order to ensure a successful injection. This includes time to palpate and figure out the trajectory of the injection site. We believe the three minutes assigned for this work by survey respondents is appropriate and are requesting 3 minutes for positioning.

Scrub, Dress, and Wait time: Last, we recommend the package time of 1 minute for scrub, dress, and wait.

Total Pre-Time: These modifications result in an overall pre-service time recommendation of 7/3/1, totaling 11 minutes for 64408.

Intra Time

Our expert panel agreed with our surveyees regarding the time for intra service work and are recommending the survey median time of 5 minutes for intra service work.

Immediate Post Time

Likewise, our experts felt that the survey's post time was an accurate reflection of the post time required for this procedure and are recommending the median post time of 6 minutes.

Physician Work

We are recommending our survey's 25th percentile of .90 for the physician work RVU. We believe the above recommendation is supported by the key reference codes, as well as crosswalk codes 64405 Injection, anesthetic agent; greater occipital nerve and 31575 Laryngoscopy, flexible; diagnostic. As the Panel is aware, 64405 is a part of this family of codes and serves as a strong comparator in work and time for 64408, we are asking that that value be reaffirmed at this meeting. In addition, 31575 is a service which has just been reviewed by the RUC and CMS and is provided by otolaryngology as the dominate specialty. We feel between these two codes survey respondents have a very clear understanding of these services and they serve as strong crosswalks for 64408. Survey respondents indicated this procedure was similar, and in many cases more, intense and complex that the selected KRS codes. We are also providing the following reference tables which include recently reviewed services which support our requested values for physician time and work for CPT 64408.

The table below compares the survey code to other RUC reviewed codes of similar time and work, providing further support that the recommended value for 64408 is appropriate.

CPT Code	Long Desc	Work RVU	Eval	Posit	SDW	Intra Time	Post Time	Total Time	RUC Review	IWPUT	MPC	2017 Utilization
20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	0.66	5	1	5	5	5	21	2016-01	0.0746	Yes	371780
20550	Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")	0.75	5	1	5	5	5	21	2016-01	0.0926		844203

64450	Injection, anesthetic agent; other peripheral nerve or branch	0.75	10	0	0	5	5	20	2011-09	0.0828		413282
51720	Bladder instillation of anticarcinogenic agent (including retention time)	0.87	5	1	3	5	5	19	2016-01	0.1199		192279
31575	Laryngoscopy, flexible; diagnostic	0.94	8	1	5	5	5	24	2015-10	0.1172		644666
64405	Injection, anesthetic agent; greater occipital nerve	0.94	7	0	0	5	10	22	2010-10	0.1118		123405
20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)	1	7	1	0	5	5	18	2011-04	0.1418		8973
65778	Placement of amniotic membrane on the ocular surface; without sutures	1	17	1	5	5	5	33	2015-04	0.0889		38047
67028	Intravitreal injection of a pharmacologic agent (separate procedure)	1.44	6	1	5	5	5	22	2009-10	0.2261		3456916
27197	Closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation	1.53	12	0	0	5	10	27	2016-01	0.2074		13357
65800	Paracentesis of anterior chamber of eye (separate procedure); with removal of aqueous	1.53	12	1	5	5	5	28	2012-04	0.2173		22624

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 88 times in 2017 per the Medicare database.

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Otolaryngology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 264
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This is the 2017 Medicare volume multipled by three in order to account for the national volume that may occur.

Specialty Otolaryngology Frequency 264 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 88 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. This is based on the 2017 volume in the Medicare database.

Specialty Otolaryngology Frequency 88 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64408

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64415 Tracking Number Original Specialty Recommended RVU: **1.42**
Presented Recommended RVU: **1.42**
Global Period: 000 Current Work RVU: **1.48** RUC Recommended RVU: **1.42**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 66-year old female has a 1-year history of tumor that is infiltrating her arm causing significant pain and interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitatingn pain, a brachial plexus block is scheduled to relieve her pain nand improve her functionn.

Percentage of Survey Respondents who found Vignette to be Typical: 44%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared.
The provider prepares the skin with an antiseptic solution, applies sterile drapes and then performs the universal protocol ("time out") with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the brachial plexus are identified. A local anesthetic skin wheal is created and placed at the site of injection. A needle is advanced towards the brachial plexus and correct position is confirmed. A local anesthetic and steroid is infiltrated into the fascial plane containing the brachial plexus using intermittent aspiration and injection. The needle is removed, and the site is observed for bleeding and then covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and evidence of a successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018		
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)		
Specialty Society(ies):	American Society of Anesthesiologists		
CPT Code:	64415		
Sample Size:	3891	**Resp N:** 57	**Response:** 1.4 %
Description of Sample:	random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**25.00**	76.00	600.00
Survey RVW:	0.70	1.42	**1.70**	2.00	10.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**4.00**		
Pre-Service Scrub, Dress, Wait Time:			**4.00**		
Intra-Service Time:	1.00	8.00	**12.00**	15.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64415	**Recommended Physician Work RVU: 1.42**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**4.00**	**6.00**	**-2.00**
Intra-Service Time:		**12.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic opioid, steroid, other solution), not including neurolygic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block), unilateral; by injection(s) (includes imaging guidance, when performed)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36620	000	1.00	**RUC Time**	577,293

CPT Descriptor 1 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	1.75	**RUC Time**	450,710

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

Other Reference CPT Code	Global	Work RVU	Time Source
51703	000	1.47	**RUC Time**

CPT Descriptor Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 13 **% of respondents:** 22.8 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 19.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 64415	Top Key Reference CPT Code: 62323	2nd Key Reference CPT Code: **64486**
Median Pre-Service Time	18.00	20.00	15.00
Median Intra-Service Time	12.00	15.00	10.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**40.00**	**45.00**	**35.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	16%	58%	25%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	50%	25%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	8%	62%	31%
Physical effort required	8%	69%	23%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	62%	31%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	36%	55%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	73%	27%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	9%	27%	64%
Physical effort required	0%	73%	27%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	45%	55%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64415 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single)* is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64415 is a 0-day global. It was previously surveyed by the RUC in 2009. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 57 responses were received from a random sample of 3,891 clinicians (1.4 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending 1.42 wRVUs (survey 25th) and time of pre (13/1/5), intra (12 min) and post (10 min)***. This results in an IWPUT of 0.070.

Vignette

The typical patient for code 64415 presents with persistent, debilitating pain interfering with the ability to complete daily activities. A brachial plexus block is performed to relieve her pain and improve her function.

The specialty did note that only 44% of the survey respondents found the vignette to be typical. The Expert Panel concluded that this was because while the vignette was for a female patient with pain in her arm, the code can be used for treatment for when the pain is throughout the brachial plexus which is a set of nerves that goes from the spinal cord in the neck down throughout the arm. The top diagnosis code reported in the 2018v2 RUC database is G89, Pain, not elsewhere classified. Survey respondents also indicated that the code is used for pre-operative pain as well as post-operative pain management for various types of orthopedic surgeries. Based on these factors the low typical vignette rate seemed reasonable.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64415 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.42	1.70	2.0
Pre		20/4/4	
Intra	8	12	15
Post		10	

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
  - 1.42 wRVUs (25th percentile)
- Time
  - Pre-time: Facility pre-service package #1 -adjusted (13/1/5)
  - Intra-time: 12 minutes (survey median)
  - Post-time 10 minutes (survey median)

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

The Expert Panel concluded that recommended wRVU value and times appropriately reflected how the service is currently performed and it aligns well within and outside of the code family.

In drafting their recommendations, the Expert Panel considered a number of factors.

Current Value

- The Expert Panel agreed that the 25th percentile of 1.42 was appropriate. It is slightly less than the current value of 1.48. The Expert Panel noted that this recommendation slightly raised the IWPUT to 0.070 from the current IWPUT of 0.0601. This was likely due to a slight decrease in the intra-service time (from 15 minutes to 12

minutes) but that this decrease of 3 minutes was accounted for in the decrease in the recommended wRVU from the current value.

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code, 62323 (*Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT*)) which was surveyed in 2015, has a wRVU of 1.80, IWPUT of .0800 and intra time of 15 minutes. The reference code includes catheter placement, infusion and image guidance. Since none of these services are included in the surveyed code (64415), the Expert Panel agreed that the higher wRVU and IWPUT for the reference code was appropriate.

Other Code with Same wRVU Value and Similar Time

- The Panel identified one RUC-surveyed 0-day global code with wRVU of 1.42 and similar time. The Expert Panel noted the slightly higher IWPUT of 64415 compared to 43200, they believed this appropriately reflected the difference of intensity and complexity between the two procedures. The Expert Panel believed code 43200 aligned well with the surveyed code and that it supported the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	1.42	15	0.0506	6,488
64415	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single**	**000**	**1.42**	**15**	**0.0700**	**175,767**

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	**N block inj brachial plexus**	**1.42**
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80
64449	N block inj lumbar plexus	1.80

Code#	Description	Proposed wRVU
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other 0-day, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
67515	Injection of medication or other substance into Tenon's capsule	000	1.40	5	0.2083	26,441
43453	Dilation of esophagus, over guide wire	000	1.41	20	0.0326	1,861
43200	Esophagoscopy, flexible, transoral; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	1.42	15	0.0516	6,488
64415	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single**	**000**	**1.42**	**15**	**0.070**	**175,767**
12004	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm	000	1.44	17	0.0697	22,716
65430	Scraping of cornea, diagnostic, for smear and/or culture	000	1.47	10	0.1067	4,674
51703	Insertion of temporary indwelling bladder catheter; complicated (eg, altered anatomy, fractured catheter/balloon)	000	1.47	15	0.0580	57,100
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed	000	1.48	11	0.0861	470,242
64487	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)	000	1.48	15	0.0661	314
15271	Application of skin substitute graft to trunk, arms, legs, total wound surface area up to 100 sq cm; first 25 sq cm or less wound surface area	000	1.50	15	0.0609	103,189
46612	Anoscopy; with removal of multiple tumors, polyps, or other lesions by hot biopsy forceps, bipolar cautery or snare technique	000	1.50	16	0.0492	66

In summary, for CPT code CPT Code 64415 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single)* ***ASA recommends 1.42 wRVUs and 19/12/10 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.

☒ Multiple codes are used to maintain consistency with similar codes.
☒ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64415

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 527301
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 460650 Percentage 87.35 %

Specialty CRNA Frequency 50937 Percentage 9.65 %

Specialty Interventional Pain Management Frequency 4060 Percentage 0.76 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 175,767 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization data

Specialty Anesthesiology Frequency 153550 Percentage 87.35 %

Specialty CRNA Frequency 16979 Percentage 9.65 %

Specialty Interventional Pain Management Frequency 1353 Percentage 0.76 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64415

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64416 Tracking Number Original Specialty Recommended RVU: **1.81**
Presented Recommended RVU: **1.81**
Global Period: 000 Current Work RVU: **1.81** RUC Recommended RVU: **1.81**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 54-year-old female has a 6-month history of tumor that is infiltrating her arm, causing constant trials and she has been unable to tolerate physical therapy or perform normal activities of daily living with her arm. Due to her persistent, debilitating pain, a brachial plexus block with a catheter and a continuous infusion of local anesthetic is scheduled to relieve her pain and allow her to participate in physical therapy to improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 55%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injection is prepared. The provider prepares the skin with an antiseptic solution, applies sterile drapes and then performs the universal protocol ("time out") with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks bordering the brachial plexus are identified and placed at the site of injection. A local anesthetic skin wheal is created. A needle is advanced towards the brachial plexus and correct position is confirmed. A catheter is advanced to lie next to the brachial plexus and subsequently, a local anesthetic and steroid is infiltrated into the fascial plane containing the brachial plexus using intermittent aspiration and injection. The needle is removed, and the site is observed for bleeding and then covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and evidence of a successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018		
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)		
Specialty Society(ies):	American Society of Anesthesiologists		
CPT Code:	64416		
Sample Size:	3891	**Resp N:** 42	**Response:** 1.0 %
Description of Sample:	Random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**18.00**	43.00	400.00
Survey RVW:	1.00	1.81	**2.10**	2.20	12.00
Pre-Service Evaluation Time:			**23.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	15.00	**20.00**	24.00	60.00

Immediate Post Service-Time:	**15.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

2-FAC Diff Pat/Straightfor Proc(no sedation/anes)

CPT Code:	64416	**Recommended Physician Work RVU: 1.81**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**18.00**	**-5.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62325	000	2.20	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64644	000	1.82	**RUC Time**	31,712

CPT Descriptor 1 Chemodenervation of one extremity; 5 or more muscles

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,043,217

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
62324	000	1.89	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 61.9 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 21.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 64416	Top Key Reference CPT Code: 62325	2nd Key Reference CPT Code: 62323
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	20.00	15.00	15.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**49.00**	**45.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	4%	12%	36%	36%	12%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	36%	36%	28%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	12%	44%	44%

Physical effort required	12%	60%	28%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	15%	42%	42%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	44%	56%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	22%	44%	33%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	67%	33%
Physical effort required	0%	78%	22%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	33%	56%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64416 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement))* is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency

around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64416 is a 0-day global. It was previously surveyed by the RUC in 2008. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 42 responses were received from a random sample of 3,891 clinicians (1.0 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending 1.81 wRVUs (survey 25th) and time of pre (19/1/5), intra (20 min) and post (15 min)***. This results in an IWPUT of 0.049.

Vignette

The vignette in the survey described a typical patient for code 64416 as someone with persistent, debilitating pain interfering with the ability to complete daily activities. A brachial plexus block with continuous infusion of an anesthetic is performed to relieve her pain and improve her function.

The specialty did note that only 55% of the survey respondents found the vignette to be typical. The Expert Panel concluded that this was because while the vignette was for a female patient with pain in her arm, the code can be used for treatment for when the pain is throughout the brachial plexus which is a set of nerves that goes from the spinal cord in the neck down throughout the arm. The top diagnosis code reported in the 2018v2 RUC database is G89, Pain, not elsewhere classified. Survey respondents also indicated that the code is used for pre-operative pain as well as post-operative pain management for various types of orthopedic surgeries. Based on these factors the low typical vignette rate seemed reasonable.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64416 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.81	2.10	2.20
Pre		23/5/5	
Intra	15	20	24
Post		15	

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
  - 1.81 wRVUs (25th percentile)
- Time
  - Pre-time: Facility pre-service package #2 -adjusted (19/1/5)
  - Intra-time: 20 minutes (survey median)
  - Post-time 15 minutes (survey median)

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

The Expert Panel concluded that recommended wRVU value and times appropriately reflected how the service is currently performed and it aligns well within and outside of the code family.

In drafting their recommendations, the Expert Panel considered a number of factors.

Current Value

- The Expert Panel agreed that the 25th percentile of 1.81, which is also the current value of the code was appropriate. The Expert Panel also noted that the intra time of 20 minutes was the same for both the current

survey as well as the previous survey conducted in 2008. This provides further evidence of the appropriateness of the recommendation.

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code, 62325 (*Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)*) which has a wRVU of 2.20, IWPUT of 0.1066 and intra time of 15 minutes. The reference code includes catheter placement, infusion and image guidance. While code 64416 includes catheter placement and infusion it does not include image guidance. Additionally, code 62325 is reported for more complex neuraxial nerve blocks while 64416 is used for peripheral nerve blocks. The Expert Panel agreed that the higher wRVU and IWPUT for the reference code was appropriate.

Other Code with Same wRVU Value and Similar Time

- The Panel identified a recently RUC-surveyed (2017) 0-day global code with wRVU of 1.81 and similar time. The Expert Panel noted the similar IWPUTs of the two codes, they believe this appropriately reflected the similar intensity and complexity between the two procedures. The Expert Panel believed code 36514 (which is included on the MPC list) aligns well with the surveyed code and that it supports the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
36514	Therapeutic apheresis; for plasma pheresis	000	1.81	20	0.0412	28,945
64416	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement**	**000**	**1.81**	**20**	**0.049**	**20,870**

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80
64449	N block inj lumbar plexus	1.80

64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other 0-day, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance	000	1.78	15	0.0816	7,763
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	000	1.80	15	0.0830	10,537
62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	000	1.80	15	0.0800	738,694
64489	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)	000	1.80	20	0.0656	1,443
64646	Chemodenervation of trunk muscle(s); 1-5 muscle(s)	000	1.80	20	0.0676	7,062
64416	**Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement**	**000**	**1.81**	**20**	**0.049**	**20,870**
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level	000	1.82	15	0.0858	247,465
32554	Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance	000	1.82	20	0.0543	16,651
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance	000	1.89	15	0.0890	25,856
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	000	1.90	15	0.0866	246

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	000	1.90	15	0.0866	2,316
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level	000	1.90	15	0.0816	1,043,217
64463	Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)	000	1.90	20	0.0605	1,066
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age	000	1.93	15	0.0842	38
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	000	1.95	15	0.0900	215,908

In summary, for CPT code CPT Code 64416 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)* ***ASA recommends 1.81 wRVUs and 25/20/15 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☒ Multiple codes are used to maintain consistency with similar codes.
   - ☒ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64416

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 62610
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 57733 Percentage 92.21 %

Specialty CRNA Frequency 4189 Percentage 6.69 %

Specialty Pain Management Frequency 351 Percentage 0.56 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 20,870 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization data

Specialty Anesthesiology Frequency 19244 Percentage 92.20 %

Specialty CRNA Frequency 1396 Percentage 6.68 %

Specialty Pain Management Frequency 117 Percentage 0.56 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64416

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64417 Tracking Number Original Specialty Recommended RVU: **1.27**
Presented Recommended RVU: **1.27**
Global Period: 000 Current Work RVU: **1.44** RUC Recommended RVU: **1.27**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; axillary nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male has a 3-year history of a painful mass in his deltoid that is interfering with his ability to complete activities of daily living. He has had poor control of his pain despite multiple medication trials and physical therapy. Due to his persistent, debilitating pain, an axillary nerve block is scheduled to relieve his pain and improve his function.

Percentage of Survey Respondents who found Vignette to be Typical: 53%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified and placed at the site of the injection. A local anesthetic skin wheal is created. A needle is advanced towards the axillary nerve and correct position is confirmed. A local anesthetic and steroid is infiltrated around the nerve using intermittent aspiration and injection. The needle is removed, and the site is observed for bleeding and then covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and evidence of a successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018		
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)		
Specialty Society(ies):	American Society of Anesthesiologists		
CPT Code:	64417		
Sample Size:	3891	**Resp N:** 45	**Response:** 1.1 %
Description of Sample:	random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**6.00**	12.00	500.00
Survey RVW:	0.68	1.27	**1.50**	2.00	12.00
Pre-Service Evaluation Time:			**21.00**		
Pre-Service Positioning Time:			**4.00**		
Pre-Service Scrub, Dress, Wait Time:			**4.00**		
Intra-Service Time:	1.00	5.00	**10.00**	18.00	35.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64417	**Recommended Physician Work RVU: 1.27**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**4.00**	**6.00**	**-2.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36620	000	1.00	**RUC Time**	577,293

CPT Descriptor 1 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	1.75	**RUC Time**	450,710

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

Other Reference CPT Code	Global	Work RVU	Time Source
62322	000	1.55	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 **% of respondents:** 33.3 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 17.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 64417	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: **62323**
Median Pre-Service Time	18.00	15.00	20.00
Median Intra-Service Time	10.00	10.00	15.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**38.00**	**35.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	7%	53%	33%	7%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	64%	36%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	13%	47%	40%
Physical effort required	13%	80%	7%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	53%	40%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	13%	13%	75%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	38%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	13%	38%	50%
Physical effort required	13%	50%	38%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	50%	38%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64417 (*Injection(s), anesthetic agent(s) and/or steroid; axillary nerve)* is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64417 is a 0-day global. It is currently a Harvard-valued code that has not been previously surveyed and was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 45 responses were received from a random sample of 3,891 clinicians (1.1 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending 1.27 wRVUs (survey 25th) and time of pre (13/1/5), intra (10 min) and post (10 min)***. This results in an IWPUT of 0.069.

Vignette

The vignette in the survey described a typical patient for code 64417 as someone with a painful mass in his deltoid that is interfering with his ability to complete activities of daily living. He has had poor control of his pain despite multiple medication trials and physical therapy. Due to his persistent, debilitating pain, an axillary nerve block is scheduled to relieve his pain and improve his function. The specialty did note that only 53% of the survey respondents found the vignette to be typical. Survey respondents indicated that the code is also used for pre-operative pain as well as post-operative pain management for various types of orthopedic surgeries. Based on these factors the low typical vignette rate seemed reasonable.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64417 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.27	1.50	2.00
Pre		21/4/4	
Intra	5	10	18
Post		10	

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
  - 1.27 wRVUs (25th percentile)
- Time
  - Pre-time: Facility pre-service package #1 -adjusted (13/1/5)
  - Intra-time: 10 minutes (survey median)
  - Post-time 10 minutes (survey median)

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

The Expert Panel concluded that recommended wRVU value and times appropriately reflect how the service is currently performed and it aligns well within and outside of the code family.

In drafting their recommendations, the Expert Panel considered a number of factors.

Current Value

- The Expert Panel agreed that the 25th percentile of 1.27 which is less than the current wRVU of 1.44 is appropriate. The Expert Panel noted that this recommendation did increase the IWPUT to 0.069 from the current IWPUT of 0.0451. This was largely due to a decrease in the intra-service time (from 19 minutes to 10 minutes). This decrease in intra-time is accounted for in the recommended wRVU decrease from the current value. Since the code was previously Harvard-valued, they felt the surveyed time more appropriately reflects current practice and the resulting IWPUT was appropriate. This position is consistent with the RUC comments on the CY 2019 NPRM for code 95970 where they state that Harvard time "holds zero validity for comparison."

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code, 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed*)) which was recently surveyed (2014), has a wRVU of 1.27, IWPUT of 0.0781and intra-time of 10 minutes. The Expert Panel noted that the codes had the same intra time but the reference code had a slightly higher IWPUT. The reference code includes catheter placement, infusion and image guidance. They concluded it was appropriate for the two codes to be valued the same, at 1.27 wRVUs.

Other Code with Same wRVU Value and Similar Time

- The Panel identified three RUC-surveyed 0-day global codes with wRVU of 1.27 and similar time. The Expert Panel noted the similar IWPUTs of the two codes, they believed this appropriately reflected the similar intensity and complexity between the two procedures.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
58301	Removal of intrauterine device (IUD)	000	1.27	15	0.0473	1,496
64417	**Injection(s), anesthetic agent(s) and/or steroid; axillary nerve**	**000**	**1.27**	**10**	**0.0690**	**13,923**
64486*	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	000	1.27	10	0.0781	7,349
67505	Retrobulbar injection; alcohol	000	1.27	10	0.0781	181

* 64486 is also the top reference code

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	**N block inj axillary**	**1.27**
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80

64449	N block inj lumbar plexus	1.80
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other 0-day, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	000	1.22	15	0.0644	50,886
40490	Biopsy of lip	000	1.22	15	0.0577	34,141
32562	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day	000	1.24	10	0.0654	1,532
49082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	000	1.24	10	0.0654	12,016
64417	**Injection(s), anesthetic agent(s) and/or steroid; axillary nerve**	**000**	**1.27**	**10**	**0.0690**	**13,923**
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	000	1.27	10	0.0781	7,349
67505	Retrobulbar injection; alcohol	000	1.27	10	0.0781	181
58301	Removal of intrauterine device (IUD)	000	1.27	15	0.0473	1,496
43450	Dilation of esophagus, by unguided sound or bougie, single or multiple passes	000	1.28	15	0.0363	72,504
46610	Anoscopy; with removal of single tumor, polyp, or other lesion by hot biopsy forceps or bipolar cautery	000	1.28	15	0.0378	166

In summary, for CPT code CPT Code 64417 (Injection(s), anesthetic agent(s) and/or steroid; axillary nerve) ***ASA recommends 1.27 wRVUs and 19/10/10 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.

☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
☒ Multiple codes are used to maintain consistency with similar codes.
☒ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64417

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Neurology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 41769
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 33035 Percentage 79.08 %

Specialty CRNA Frequency 5309 Percentage 12.71 %

Specialty Neurology Frequency 1846 Percentage 4.41 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 13,923 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization data

Specialty Anesthesiology Frequency 11012 Percentage 79.09 %

Specialty CRNA Frequency 1770 Percentage 12.71 %

Specialty Neurology Frequency 615 Percentage 4.41 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:

Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64417

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64420 Tracking Number Original Specialty Recommended RVU: **1.24**
Presented Recommended RVU: **1.18**
Global Period: 000 Current Work RVU: **1.18** RUC Recommended RVU: **1.18**

CPT Descriptor: Injection(s), anesthetic agent(s), and/or steroid; intercostal nerve, single level

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old female has a 2-year history of rib pain that is interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a trial of intercostal nerve block is scheduled to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The provider cleans the skin with an antiseptic solution, applies a sterile drape, and then performs the universal protocol ("time out") with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified and placed at the site of the injection. A local anesthetic skin wheal is created. A needle is advanced at an angle of approximately 20° cephalad to the skin until the rib is contacted. With the same angle of insertion, the needle is walked off the inferior border of the rib and advanced 3 mm to place the tip in the space containing the neurovascular bundle between the internal and innermost intercostal muscles. After negative aspiration, a local anesthetic is injected. The needle is removed, and the site is observed for bleeding and covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and evidence of a successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Marc Leib, MD (ASA); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Academy of Pain Medicine; American Academy of Physical Medicine and Rehabilition, American Society of Anesthesiologists				
CPT Code:	64420				
Sample Size:	2452	**Resp N:**	60	**Response:** 2.4 %	
Description of Sample:	random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**10.00**	25.00	500.00
Survey RVW:	0.75	1.24	**1.50**	1.86	30.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	8.00	**10.00**	15.00	30.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64420	**Recommended Physician Work RVU: 1.18**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**18.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64493	000	1.52	**RUC Time**

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64483	000	1.90	**RUC Time**

CPT Descriptor Injection(s), anesthetic agent andor steroid, transforaminal epidural, with imaging guidance (fluroscopy or CT); lumbar or sacral, single level

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36620	000	1.00	**RUC Time**	577,293

CPT Descriptor 1 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	1.75	**RUC Time**	450,710

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

Other Reference CPT Code	Global	Work RVU	Time Source
62322	000	1.55	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 23 **% of respondents:** 38.3 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 21.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 64420	Top Key Reference CPT Code: 64493	2nd Key Reference CPT Code: **64483**
Median Pre-Service Time	19.00	17.00	24.00
Median Intra-Service Time	10.00	15.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**34.00**	**42.00**	**49.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	52%	35%	9%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	61%	30%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	13%	52%	35%
Physical effort required	4%	78%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	35%	52%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	15%	23%	46%	15%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	46%	46%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	23%	69%
Physical effort required	8%	46%	46%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	15%	77%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64420 (*Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level)* is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64420 is currently a Harvard-valued code that has not been previously surveyed. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA), the American Academy of Pain Medicine (AAPM) and the American Academy of Physical Medicine & Rehabilitation (AAPM&R).

October 2018 RUC Meeting Recommendation Rationale

A total of 60 responses were received from a random sample of 2,452 clinicians (2.4 percent response rate). ASA, AAPM and AAPM&R convened an Expert Panel to review the survey data. ***The societies are recommending maintaining the current value of 1.18 wRVUs and time of pre (13/1/5), intra (10 min) and post (10 min)***. This results in an IWPUT of 0.060.

Vignette

The vignette described a typical patient for code 64420 as a 48-year-old female with a 2-year history of rib pain that is interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a trial of intercostal nerve block is scheduled to relieve her pain and improve her function. 97% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64420 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.24	1.50	1.86
Pre		25/5/5	
Intra	8	10	15
Post		10	

After review of the reviewer comments of the societies original recommended wRVU of 1.24 and time inputs, the Expert Panel agreed to recommend the following revised work RVU and time recommendation:

- wRVU
  - 1.18 wRVU (recommending maintaining the current value)
- Time
  - Pre-time: Facility pre-service package #1 -adjusted (13/1/5)
  - Intra-time: 10 minutes (survey median)
  - Post-time 10 minutes (survey median)

Crosswalk

Our recommended work RVU is supported by a crosswalk to code **67810** (*Incisional biopsy of eyelid skin including lid margin*); [wRVU=1.18; time=11/13/3; IWPUT=0.0688; RUC 2011].

The Expert Panel also concluded that recommended wRVU value and align well within and outside of the code family.

Current Value

- The current value of code 64420 is 1.18 wRVU
- The recommended wRVU of 1.18, which is less than the survey 25th percentile of 1.24, maintains this value

Comparison to Other Codes

- The Expert Panel compared the recommendation for 64420 to other codes and identified other 0-day global codes with similar intra-time. These comparisons indicated the code was aligned with other codes of similar time and value.

CPT Code	Long Desc	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	000	1.14	15	0.059	146,808
45331	Sigmoidoscopy, flexible; with biopsy, single or multiple	000	1.14	15	0.0345	36,331
64420	**Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level**	**000**	**1.18**	**10**	**0.060**	**3,762**
67810	Incisional biopsy of eyelid skin including lid margin	000	1.18	13	0.0688	30,330
46606	Anoscopy; with biopsy, single or multiple	000	1.2	11	0.0443	2,185
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	000	1.2	15	0.04	5,630
44385	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	1.2	15	0.037	1,359
57100	Biopsy of vaginal mucosa; simple (separate procedure)	000	1.2	15	0.0427	5,797
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	000	1.2	15	0.06	7,650
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	000	1.22	15	0.0644	50,886
40490	Biopsy of lip	000	1.22	15	0.0577	34,141
32562	Instillation(s), via chest tube/catheter, agent for fibrinolysis (eg, fibrinolytic agent for break up of multiloculated effusion); subsequent day	000	1.24	10	0.0654	1,532
49082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	000	1.24	10	0.0654	12,016

In summary, for CPT Code 64420 (Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level***) ASA, AAPM, and AAPM&R recommend 1.18 wRVUs and 19/10/10 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64420

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 11286
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 4518 Percentage 40.03 %

Specialty Interventional Pain Management Frequency 1290 Percentage 11.43 %

Specialty Pain Management Frequency 1260 Percentage 11.16 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,762
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology Frequency 1506 Percentage 40.03 %

Specialty Interventional Pain Management Frequency 430 Percentage 11.43 %

Specialty Pain Management Frequency 420 Percentage 11.16 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64420

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64421 Tracking Number Original Specialty Recommended RVU: **0.60**
Presented Recommended RVU: **0.60**
Global Period: ZZZ Current Work RVU: **1.68** RUC Recommended RVU: **0.60**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old female has a 3-year history of persistent rib pain following a fall that resulted in multiple rib fractures. The pain is interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a trial of intercostal nerve blocks involving multiple intercostal spaces is scheduled to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: N/A

Description of Intra-Service Work: After the initial intercostal nerve block, additonal intercostal nerve blocks are performed at other levels. After cleaning the skin with an antiseptic solution, 1-2 mL of dilute local anesthetic is infiltrated subcutaneously at the planned injection site at the inferior border of the rib. A needle is advanced at an angle of approximately 20° cephalad to the skin till the rib is contacted.With the same angle of insertion, the needle is walked off the inferior border of the rib and advanced 3 mm to place the tip in the space containing the neurovascular bundle between the internal and innermost intercostal muscles. After negative aspiration, local anesthetic is deposited at each of the sites. The needle is removed, and the sites are covered with a sterile occlusive dressing.

Description of Post-Service Work: N/A

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018					
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Marc Leib, MD (ASA); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA)					
Specialty Society(ies):	American Academy of Pain Medicine; American Academy of Physical Medicine and Rehabilitation; American Society of Anesthesiologists					
CPT Code:	64421					
Sample Size:	2452	**Resp N:**	60	**Response:** 2.4 %		
Description of Sample:	random					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**10.00**	21.00	500.00
Survey RVW:	0.60	1.00	**1.24**	1.50	3.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	8.00	**10.00**	15.00	35.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

Select Pre-Service Package

CPT Code:	64421	**Recommended Physician Work RVU: 0.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

Select Post-Service Package

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64462	ZZZ	1.10	**RUC Time**

CPT Descriptor Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64484	ZZZ	1.00	**RUC Time**

CPT Descriptor Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64484	ZZZ	1.00	**RUC Time**	450,460

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64480	ZZZ	1.20	**RUC Time**	22,183

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
15274	000	0.80	**RUC Time**

CPT Descriptor Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 17 **% of respondents:** 28.3 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 21.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 64421	Top Key Reference CPT Code: 64462	2nd Key Reference CPT Code: **64484**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	10.00	15.00	10.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**10.00**	**15.00**	**10.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	35%	29%	35%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	41%	41%	18%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	24%	35%	41%

Physical effort required	24%	53%	24%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	24%	35%	41%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	8%	62%	31%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	62%	31%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	15%	54%	31%
Physical effort required	0%	85%	15%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	46%	46%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code +64421 (*Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide

further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code +64421is currently a Harvard-valued code 0-day global code. The new code has been changed to an add-on code reported with base code 64420. A ZZZ global period has been assigned to the new code. Code +64421 was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA), the American Academy of Pain Medicine (AAPM) and the American Academy of Physical Medicine & Rehabilitation (AAPM&R).

October 2018 RUC Meeting Recommendation Rationale

A total of 60 responses were received from a random sample of 2,452 clinicians (2.4 percent response rate). ASA, AAPM and AAPM&R convened an Expert Panel to review the survey data. ***The societies are recommending 0.60 wRVUs and 10 minutes of intra-time.*** This results in an IWPUT of 0.060.

Vignette

The typical patient presents with persistent, debilitating pain, and receives a trial of intercostal nerve blocks involving multiple intercostal spaces. 97% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

+64421 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.00	1.24	1.50
Intra	8	10	15

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
  - 0.60 wRVUs which is based on a crosswalk
- Time
  - 10 minutes intra time

The Panel noted that the survey intra-time for +64421 was the same as the surveyed intra-time for 64420. Similar intra-service time for the codes was appropriate since they both described a single injection of an intercostal nerve.

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

In drafting their recommendations, the Expert Panel considered a number of factors.

Crosswalk

- The Expert Panel selected the code 77063 (Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)) as the crosswalk. The ZZZ code has a wRVU of 0.60 wRVUs and intra-time of 8 minutes. It was reviewed by the RUC in 2014. The Expert Panel agreed that +64421 aligned well both for wRVW value and intensity/complexity factors.

Relationship to Base Code

- The Expert Panel tested the appropriateness of the recommended wRVU of 0.60 by backing out the pre and post time from the recommended wRVU for the base code of 64420. This resulted in a wRVU value of 0.67. While this value was a little higher than the recommended value, the Expert Panel found this to be additional evidence of the appropriateness of the recommended wRVU.
  - 1.24 – [(13x.0224) + (1x.0224) + (5x.0081) + (10x.0224)] = 0.67

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code, +64462 *(Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)*) which has a wRVU of 1.10, IWPUT of 0.0733 and intra time of 15 minutes. The Expert Panel noted that the reference code carries more intra time so the higher value was for the reference code was appropriate.

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	**N block inj intercost sng, addl level**	**0.60**
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80
64449	N block inj lumbar plexus	1.80
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other ZZZ, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
+77002	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	ZZZ	0.54	15	0.0330	481,426
+96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and	ZZZ	0.55	15	0.0367	3

	gastrointestinal tract)					
+64421	**Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)**	**ZZZ**	**0.60**	**10**	**0.060**	**17,692**
+77003	Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)	ZZZ	0.60	15	0.0370	68,387
+77063*	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)	ZZZ	0.60	8	0.0750	2,777,164
+78020	Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)	ZZZ	0.60	20	0.0300	1,056
+95887	Needle electromyography, non-extremity (cranial nerve supplied or axial) muscle(s) done with nerve conduction, amplitude and latency/velocity study (List separately in addition to code for primary procedure)	ZZZ	0.71	20	0.0355	14,162

* Also, selected as the crosswalk

In summary, for CPT Code +64421 (*Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure*) ***ASA, AAPM, and AAPM&R recommend 0.60 wRVUs and 0/10/0 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 64420, Injection(s), anesthetic agent(s), and/or steriod; intercostal nerve, single level; 0-day global; 1.24 wRVU; time=19/10/10 (recommended at Oct 2018 RUC meeting)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64421

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 53076
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Mediccare utilization

Specialty Anesthesiology Frequency 16799 Percentage 31.65 %

Specialty Interventional Pain Management Frequency 10483 Percentage 19.75 %

Specialty Pain Management Frequency 9787 Percentage 18.43 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 17,692 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilizationn

Specialty Anesthesiology Frequency 5600 Percentage 31.65 %

Specialty Interventional Pain Management Frequency 3494 Percentage 19.74 %

Specialty Pain Management Frequency 3262 Percentage 18.43 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64421

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64425 Tracking Number Original Specialty Recommended RVU: **1.19**
Presented Recommended RVU: **1.19**
Global Period: 000 Current Work RVU: **1.75** RUC Recommended RVU: **1.19**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old male has a 3-year history of pain in his groin following an open inguinal hernia repair that is interfering with his ability to complete activities of daily living. He has had poor control of his pain despite multiple medication trials and physical therapy. Due to persistent, debilitating pain, a trial of ilioinguinal /iliohypogastric nerve block is scheduled to relieve pain and improve function.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed procedure is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The skin is cleansed with an antiseptic solution, sterile drapes are applied and then the provider performs the universal protocol ("time out") with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are idnetified. The anterior superior iliac spine is palpated and the target insertion site is marked 2 cm medial and 2 cm inferior to the anterior superior iliac spine. A local anesthetic skin wheal is created and then a needle is advanced through the external oblique muscle. A loss of resistance is appreciated as the needle passes through the muscle to lie between it and the internal oblique. After the initial loss of resistance, the needle is advanced again until a loss of resistance is encountered as the needle passes through the internal oblique muscle and is in the plane between the internal oblique and the transversus abdominus muscle. Following negative aspiration, a local anesthetic and steroid is injected. The needle is removed, and the site is observed for bleeding and covered with a sterile occlusive dressing.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Marc Leib, MD (ASA); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Academy of Pain Medicine; American Academy of Physical Medicine and Rehabilitation; American Society of Anesthesiologists				
CPT Code:	64425				
Sample Size:	2452	**Resp N:**	54	**Response:** 2.2 %	
Description of Sample:	random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**8.00**	23.00	500.00
Survey RVW:	0.84	1.19	**1.30**	1.59	30.00
Pre-Service Evaluation Time:			**24.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	10.00	**11.00**	15.00	31.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64425	**Recommended Physician Work RVU: 1.19**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**1.00**	**1.00**	**0.00**
Intra-Service Time:		**11.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**18.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64493	000	1.52	**RUC Time**

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36620	000	1.00	**RUC Time**	577,239

CPT Descriptor 1 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
36556	000	1.75	**RUC Time**	450,710

CPT Descriptor 2 Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older

Other Reference CPT Code	Global	Work RVU	Time Source
40490	000	1.22	**RUC Time**

CPT Descriptor Biopsy of lip

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 25 **% of respondents:** 46.2 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 14.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 64425	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: 64493
Median Pre-Service Time	9.00	15.00	17.00
Median Intra-Service Time	11.00	10.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**25.00**	**35.00**	**42.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	84%	12%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	80%	20%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	64%	28%
Physical effort required	4%	84%	12%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	92%	8%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	38%	25%	25%	13%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	63%	13%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	38%	38%	25%
Physical effort required	13%	75%	13%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	63%	13%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64425 (*Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves)* is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64425 is currently a Harvard-valued code that has not been previously surveyed. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA), the American Academy of Pain Medicine (AAPM) and the American Academy of Physical Medicine & Rehabilitation (AAPM&R).

October 2018 RUC Meeting Recommendation Rationale

A total of 54 responses were received from a random sample of 2,452 clinicians (2.2 percent response rate). ASA, AAPM and AAPM&R convened an Expert Panel to review the survey data. ***The societies are recommending 1.19 wRVUs (survey 25th) and time of pre (7/0/1), intra (11 min) and post (10 min)***. This results in an IWPUT of 0.073.

Vignette

The typical patient was describes as experiencing persistent, debilitating pain, a trial of ilioinguinal /iliohypogastric nerve block is scheduled to relieve pain and improve function. 94% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64425 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.19	1.30	1.59
Pre		24/5/5/	
Intra	10	11	15
Post		10	

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
  - 1.19 wRVU (25th percentile)
- Time
  - Pre-time: Non-facility pre-service package #5 -adjusted (7/0/1)
  - Intra-time: 11 minutes (survey median)
  - Post-time 10 minutes (survey median)

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

The Expert Panel concluded that recommended wRVU value and times appropriately reflect how the service is currently performed and it aligns well within and outside of the code family.

In drafting their recommendations, the Expert Panel considered a number of factors.

Current Value

- The Expert Panel agreed that the 25th percentile of 1.19 wRVUs which is less than the current wRVU of 1.75 is appropriate. The Expert Panel noted that this recommendation decreased the IWPUT to 0.073 from the current IWPUT of 0.0928. Since the code was previously Harvard-valued, they felt the surveyed time more appropriately reflects current practice and the recommended wRVU and resulting IWPUT was appropriate. This position is consistent with the RUC comments on the CY 2019 NPRM for code 95970 where they state that Harvard time "holds zero validity for comparison."

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code, 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed*)) which was surveyed in 2014, has a wRVU of 1.27,

IWPUT of 0.0781 and intra time of 10 minutes. The Expert Panel noted that the codes had the same intra time and a slightly higher IWPUT. They concluded the reference code supported the recommendation of 1.19 wRVUs for code 64425.

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	N block other peripheral	0.84
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	**N block inj ilio-ing/hypogi**	**1.19**
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80
64449	N block inj lumbar plexus	1.80
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other 0-day global codes, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
45305	Proctosigmoidoscopy, rigid; with biopsy, single or multiple	000	1.15	10	0.0549	668
44382	Ileoscopy, through stoma; with biopsy, single or multiple	000	1.17	20	0.0262	1,520
67810	Incisional biopsy of eyelid skin including lid margin	000	1.18	13	0.0688	30,330
64425	**Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves)**	**000**	**1.19**	**11**	**0.073**	**7,404**
46606	Anoscopy; with biopsy, single or multiple	000	1.20	11	0.0443	2,185
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access	000	1.20	15	0.0400	5,630

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
44385	Endoscopic evaluation of small intestinal pouch (eg, Kock pouch, ileal reservoir [S or J]); diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	1.20	15	0.0370	1,359
57100	Biopsy of vaginal mucosa; simple (separate procedure)	000	1.20	15	0.0427	5,797
57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	000	1.20	15	0.0600	7,650

In summary, for CPT Code 64425 (*Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves)* ***ASA, AAPM, and AAPM&R recommend 1.19 wRVUs and 8/11/10 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64425

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Pain Management How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 22212
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilizationn

Specialty Anesthesiology Frequency 7923 Percentage 35.66 %

Specialty Pain Management Frequency 2728 Percentage 12.28 %

Specialty Interventional Pain Management Frequency 2619 Percentage 11.79 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,404
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology Frequency 2641 Percentage 35.66 %

Specialty Pain Management Frequency 909 Percentage 12.27 %

Specialty Interventional Pain Management Frequency 873 Percentage 11.79 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64425

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64430 Tracking Number H11 Original Specialty Recommended RVU: **1.15**
Presented Recommended RVU: **1.15**
Global Period: 000 Current Work RVU: **1.46** RUC Recommended RVU: **1.15**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; pudendal nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 48-year-old female has a 2-year history of pudendal neuralgia that is interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a trial of pudendal nerve block is scheduled to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The procedure is thoroughly explained to the patient ensuring the patient's understanding of the procedure and expected outcomes. The risks, benefits, and potential complications of the procedure are discussed. Informed consent is obtained and the appropriate instruments and materials are prepared. The patient changes into a gown and has a pelvic drape. The patient is placed in the dorsal lithotomy position and appropriate pelvic draping is completed.

Description of Intra-Service Work: A time out is performed. A bimanual examination is performed for determination of internal pelvic anatomy. Concentrated digital evaluation of the levator muscles, pelvic ligaments and the ischial spines is performed. The provider proceeds with povidone cleansing of the entire vaginal canal and cervix. The speculum is removed. A 10cc control syringe is filled with local anesthetic with or without epinephrine. A spinal needle is attached to the 10cc syringe. Sterile gloves are donned and the provider again palpates the ischial spine and sacrospinous ligament. Introduction of the needle guide / trumpet is performed aligning with the providers digital palpation of the injection site. The spinal needle is directed into the needle guide and an initial injection of the anesthetic is performed of the vaginal tissue. The needle is advanced through the vaginal epithelium to the sacrospinous ligament. Aspiration is performed to ensure no vascular perforation has occurred and further injection is performed. The needle is advanced again slightly monitoring for loss of resistance, signifying complete penetration of the sacrospinous ligament and entrance into the region of pudendal nerve. Aspiration is again performed to ensure no perforation of the major pelvic vessels. The anesthetic is injected slowly to monitor adverse effects of possible intravascular injection. The trumpet and needle are removed. A speculum is placed and hemostasis is confirmed at the injection site. The operator may choose to use more than 10cc of anesthetic and therefore the syringe may require refilling and repeat injection or a second syringe may be used. If bleeding is encountered, a large procto-swab is held in place to exert pressure on any bleeding sites. Proctoswabs are utilized for cleaning the posterior fourchette of any blood or extruded anesthetic.

Description of Post-Service Work: After the procedure is complete, the provider will evaluate the effects of the anesthetic on the nerve distribution. The provider monitors the patient for possible systemic reactions related to intravascular injection. Write post-procedure orders for care and pain medication. Create procedure note.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	George Hill, MD, Jon Hathaway, MD, Mitch Schuster, MD, Richard Rosenquist, MD, Neil Cohen, MD, Marc Leib, MD, Eduardo Fraifeld, MD and Gregory Polston, MD				
Specialty Society(ies):	ACOG, ASA, AAPM				
CPT Code:	64430				
Sample Size:	5489	**Resp N:**	67	**Response:** 1.2 %	
Description of Sample:	Random samples from ACOG (4000), ASA (989) and AAPM (500)				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**5.00**	18.00	500.00
Survey RVW:	0.10	1.15	**1.50**	1.89	3.60
Pre-Service Evaluation Time:			**22.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	5.00	**10.00**	15.00	35.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64430	**Recommended Physician Work RVU: 1.15**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**5.00**	**1.00**	**4.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64644	000	1.82	**RUC Time**

CPT Descriptor Chemodenervation of one extremity; 5 or more muscles

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
23350	000	1.00	**RUC Time**	37,824

CPT Descriptor 1 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64644	000	1.82	**RUC Time**	31,712

CPT Descriptor 2 Chemodenervation of one extremity; 5 or more muscles

Other Reference CPT Code	Global	Work RVU	Time Source
64483	000	1.90	**RUC Time**

CPT Descriptor Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 13.4 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 11.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 64430	Top Key Reference CPT Code: 64644	2nd Key Reference CPT Code: **62323**
Median Pre-Service Time	23.00	15.00	20.00
Median Intra-Service Time	10.00	25.00	15.00
Median Immediate Post-service Time	10.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**43.00**	**45.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	33%	67%	0%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	67%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	67%	22%
Physical effort required	11%	44%	44%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	56%	33%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	12%	38%	12%	38%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	38%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	13%	25%	63%
Physical effort required	0%	38%	63%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	38%	38%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64430 is part of the larger Somatic Nerve Injection family, which represents revisions of descriptors and guidelines for codes 64400- 64450 and deletion of 3 codes to clarify reporting (ie, separate reporting of imaging guidance, number of units, change of CPT codes 64421 from a 0-day global to ZZZ).

Time

Pre-time package 1:Straightforward Patient/Straightforward Procedure (No anesthesia care). Added five minutes for the Dorsal Lithotomy position (then reduced by one minute due to survey data). Reduced SDW one minute due to survey data.

Post-time package 7a: 7A Local Anesthesia/ Straightforward Procedure. Reduced time by eight minutes due to survey data.

Other Reference Code
We included 64483 as another reference code on the SOR. The survey respondents chose this code eight times, the same number of respondents that chose CPT Code 62323.

Billed Together
CPT Code 64430 is not typically billed with another service, nor is it typically billed with an E/M (23%).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64430

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty obstetrics/gynecology How often? Commonly

Specialty anesthesiology How often? Commonly

Specialty pain management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national number is not known.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 3,388
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Current RUC database indicates 3,388 Medicare claims in 2017.

Specialty obstetrics/gynecology Frequency 949 Percentage 28.01 %

Specialty anesthesiology Frequency 712 Percentage 21.01 %

Specialty pain management Frequency 407 Percentage 12.01 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64430

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64435 Tracking Number H12 Original Specialty Recommended RVU: **0.75**
Presented Recommended RVU: **0.75**
Global Period: 000 Current Work RVU: **1.45** RUC Recommended RVU: **0.75**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; paracervical (uterine) nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 34-year-old female with an IUD presented for removal. The IUD string was not identified on exam and initial probing of the cervical canal was not tolerated by the patient. Cervical dilation under cervical anesthesia is required for retrieval.

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The procedure is thoroughly explained to the patient ensuring the patient's understanding of the need for the procedure. The risks, benefits, and potential complications of the procedure are discussed. Informed consent is obtained and the appropriate instruments and materials are prepared. The patient is placed in the dorsal lithotomy position and appropriate draping is completed.

Description of Intra-Service Work: The provider places a speculum into the vagina. The speculum is positioned so that the cervix is centered in the operative field. The cervix and lateral vagina are cleaned with an appropriate solution. A 10cc syringe is filled with local anesthetic with or without epinephrine. The provider places a single tooth tenaculum at the 12 o'clock position of the cervix to stabilize the organ. A spinal needle is attached to the 10cc syringe. Initial aspirations and then injections of the anesthetic are placed into the cervix at the 3 and 9 o'clock position or the 2, 4, 8, and 10 o'clock positions. The anesthetic is injected slowly to ascertain infiltration of the stroma of the cervix. Hemostasis is confirmed at each injection site after injection. After the procedure, often bleeding is encountered from the injection site causing the need to hold pressure with pronto-swabs until stable. Once the procedure is complete, the operator will wait for complete anesthetic effect.

Description of Post-Service Work: After the procedure is complete, the provider will evaluate the effects of the anesthetic on the nerve distribution to observe possible untoward effects. The provider monitors the patient for possible systemic reactions related to intravascular injection and possible hematoma development in the retroperitoneal space. Write post-procedure orders for care and pain medication. Create procedure note.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	George Hill, MD, Jon Hathaway, MD and Mitch Schuster				
Specialty Society(ies):	ACOG				
CPT Code:	64435				
Sample Size:	4000	**Resp N:** 42	**Response:** 1.0 %		
Description of Sample:	Random samples from ACOG (4000)				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**18.00**	50.00	500.00
Survey RVW:	0.60	0.75	**1.00**	1.20	2.75
Pre-Service Evaluation Time:			**10.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	1.00	3.00	**5.00**	10.00	30.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64435	**Recommended Physician Work RVU: 0.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**3.00**	**0.00**	**3.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**1.00**	**-1.00**
Intra-Service Time:		**5.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
20551	000	0.75	**RUC Time**

CPT Descriptor Injection(s); single tendon origin/insertion

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
57500	000	1.20	**RUC Time**

CPT Descriptor Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20552	000	0.66	**RUC Time**	371,780

CPT Descriptor 1 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
23350	000	1.00	**RUC Time**	37,824

CPT Descriptor 2 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 28.5 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 26.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 64435	Top Key Reference CPT Code: 20551	2nd Key Reference CPT Code: **57500**
Median Pre-Service Time	10.00	10.00	9.00
Median Intra-Service Time	5.00	5.00	15.00
Median Immediate Post-service Time	5.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**20.00**	**29.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	50%	50%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	50%	42%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	8%	25%	67%
Physical effort required	8%	42%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	17%	42%	42%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	9%	45%	45%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	45%	36%	18%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	9%	18%	73%
Physical effort required	9%	73%	18%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	18%	45%	36%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64435 is part of the larger Somatic Nerve Injection family, which represents revisions of descriptors and guidelines for codes 64400- 64450 and deletion of 3 codes to clarify reporting (ie, separate reporting of imaging guidance, number of units, change of CPT codes 64421 from a 0-day global to ZZZ).

Time

CPT Code 64435 is typically peformed in the non facility setting, with minimal anesthesia care. As such, we selected pre time package 5 and removed 1 minute for no anesthesia care. Three minutes were added to positioning to account for the dorsal lithotomy positioning (survey data was 3 minutes).

Billed Together
CPT Code 64435 is not typically billed with another service, nor is it typically billed with an E/M (0%).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64435

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty obstetrics/gynecology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. A national number is not known

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 78 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Current RUC database (2017 utilization)

Specialty obstetrics/gynecology Frequency 36 Percentage 46.15 %

Specialty Frequency Percentage %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64435

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64445 Tracking Number Original Specialty Recommended RVU: **1.47**
Presented Recommended RVU: **1.30**
Global Period: 000 Current Work RVU: **1.48** RUC Recommended RVU: **1.30**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 25-year-old female has just undergone a right trimalleolar fracture open reduction and fixation, and the surgeon consults the anesthesiologist for pain management in the recovery room. The planned technique is a sciatic nerve block, to which the patient consents.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed injection is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The skin is cleansed with an antiseptic solution and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created and placed at injection site.The skin at the proposed entry site is anesthetized with a small amount of local anesthetic via a small-gauge needle. An insulated stimulating needle is inserted through the skin in the gluteal region. A nerve stimulator is turned on and the patient is monitored for reports of paresthesia or appropriate muscle twitches in the leg in response to nerve stimulation. The current on the nerve stimulator is reduced to confirm proximity of the needle to the sciatic nerve and to reposition if necessary to maintain a muscle twitch in the appropriate distribution with a low current. Once correct needle position is obtained, the needle is aspirated to confirm the absence of blood. Following negative aspiration, administer a small test dose of local anesthetic, monitor the patient's VS, and question the patient about symptoms of intravascular local anesthetic injection. If there are no signs or symptoms of intravascular injection, inject local anesthetic in incremental doses with frequent aspiration to avoid intra-vascular injection. After completion of the injection, remove the needle. Observe the patient for any signs or symptoms of local anesthetic toxicity. After several minutes have passed, evaluate the initial effects of the sciatic nerve block by physical examination to determine if the patient is developing weakness, numbness, and relief of pain in the expected nerve distribution.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018					
Presenter(s):	Neal Cohen, MD (ASA); Matthew Grierson, MD (AAPM&R); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)					
Specialty Society(ies):	American Academy of Physical Medicine and Rehabilitation; American Society of Anesthesiologists					
CPT Code:	64445					
Sample Size:	6346	**Resp N:**	68	**Response:** 1.0 %		
Description of Sample:	random					

	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	10.00	**24.50**	50.50	1000.00
Survey RVW:	0.80	1.30	**1.51**	1.83	10.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**3.50**		
Pre-Service Scrub, Dress, Wait Time:			**4.00**		
Intra-Service Time:	1.00	6.00	**10.00**	13.25	30.00

Immediate Post Service-Time:	**6.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64445	**Recommended Physician Work RVU: 1.30**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**1.00**	**1.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64483	000	1.90	**RUC Time**

CPT Descriptor Injection(s), anesthetic agent andor steroid, transforaminal epidural, with imaging guidance (fluroscopy or CT); lumbar or sacral, single level

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
23350	000	1.00	**RUC Time**	37,824

CPT Descriptor 1 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64644	000	1.82	**RUC Time**	31,712

CPT Descriptor 2 Chemodenervation of one extremity; 5 or more muscles

Other Reference CPT Code	Global	Work RVU	Time Source
62324	000	1.89	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 19 **% of respondents:** 27.9 **%**

Number of respondents who choose 2nd Key Reference Code: 10 **% of respondents:** 14.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 64445	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: 64483
Median Pre-Service Time	9.00	15.00	24.00
Median Intra-Service Time	10.00	10.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**24.00**	**35.00**	**49.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	6%	6%	61%	22%	6%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	26%	42%	32%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	39%	45%
Physical effort required	17%	44%	40%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	12%	56%	34%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	20%	50%	30%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	40%	30%	30%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	10%	50%	40%
Physical effort required	10%	60%	30%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	30%	50%	20%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64445 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single)* is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64445 was previously surveyed by the RUC in 2009. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA) and the American Academy of Physical Medicine & Rehabilitation (AAPM&R).

October 2018 RUC Meeting Recommendation Rationale

A total of 68 responses were received from a random sample of 6,346 clinicians (1.0 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending a value of 1.30 wRVUs (25th percentile) and time of pre (7/1/1), intra (10 min) and post (6 min)***. This results in an IWPUT of 0.098.

Vignette

The typical patient has just undergone a right trimalleolar fracture open reduction and fixation, and the surgeon consults the anesthesiologist for pain management in the recovery room. 85% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64445 Highlights from Survey Data			
	25th Percentile	Median	75th Percentile
Work	1.30	1.51	1.83
Pre		15/3.5/4	
Intra	6	10	13.25
Post		6	

After review of the reviewer comments of the societies original recommended wRVU of 1.47 and time inputs, the Expert Panel agreed to recommend the following revised work RVU and time recommendations as interim and to resurvey for the January 2019 RUC meeting:

- wRVU
  - 1.30 wRVU based on survey 25th percentile
- Time
  - Pre-time: Non-facility pre-service package #5 (7/1/1); 1 minute added for positioning
  - Intra-time: 10 minutes (survey median)
  - Post-time 6 minutes (survey median)

Survey 25th Percentile

The specialties societies' recommendation of 1.30 is based on the survey's 25th percentile.

In summary, for CPT code CPT Code 64445 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single*) ***ASA and AAPM&R recommend 1.30 wRVUs and 7/10/6 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64445

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology	How often? Commonly
Specialty Internal Medicine	How often? Commonly
Specialty General Practice	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 358560
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilizationn

Specialty Anesthesiology	Frequency 132165	Percentage 36.85 %
Specialty Internal Medicine	Frequency 60382	Percentage 16.84 %
Specialty General Practice	Frequency 29079	Percentage 8.10 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 119,520 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilizationn

Specialty Anesthesiology	Frequency 44055	Percentage 36.85 %
Specialty Internal Medicine	Frequency 20127	Percentage 16.83 %
Specialty General Practice	Frequency 9693	Percentage 8.10 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64445

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64446 Tracking Number Original Specialty Recommended RVU: **1.80**
Presented Recommended RVU: **1.70**
Global Period: 000 Current Work RVU: **1.81** RUC Recommended RVU: **1.54**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male suffers a crushed left foot in an automobile accident. He undergoes major reconstruction of his left foot and ankle under general anesthesia. The surgeon requests a block with continuous infusion to manage post-operative pain and facilitate rehabilitation. In order to provide post-operative pain control, a continuous sciatic nerve block is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. An intravenous infusion is initiated and supplemental oxygen is provided. The site of the proposed injection is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injection is prepared. The skin is cleansed with a antiseptic solution and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created at the planned needle insertion site. A Touhy needle is advanced toward the sciatic nerve. A nerve stimulator is attached to the needle and the needle is advanced until it is close to the nerve. A brisk motor response in the ankle, foot or toes is noted with less than 0.4 mA stimulation. A catheter is then advanced through the Tuohy needle until it is 3 – 10 cm beyond its tip. The electrical connection is then transferred to the catheter and nerve stimulation is again evaluated to confirm that the catheter is lying next to the nerve. The Tuohy needle is removed, the catheter secured in place and 15-20 ml of a local anesthetic is injected through the catheter. Block of the sciatic nerve is then assessed over the next 15-30 minutes and an infusion of a dilute local anesthetic is started. Subcutaneous tunneling, affixation, and dressing of the catheter must be done carefully as this area is prone to bacterial contamination both during and after the procedure.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018		
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)		
Specialty Society(ies):	American Society of Anesthesiologists		
CPT Code:	64446		
Sample Size:	3894	**Resp N:** 48	**Response:** 1.2 %
Description of Sample:	random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**20.00**	37.00	1000.00
Survey RVW:	1.00	1.80	**2.19**	2.33	10.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**4.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	10.00	**15.00**	19.00	30.00

Immediate Post Service-Time:	**6.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64446	**Recommended Physician Work RVU: 1.54**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**6.00**	**18.00**	**-12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62325	000	2.20	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64644	000	1.82	**RUC Time**	31,712

CPT Descriptor 1 Chemodenervation of one extremity; 5 or more muscles

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,043,217

CPT Descriptor 2 njection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
62324	000	1.89	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 54.1 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 16.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 64446	Top Key Reference CPT Code: 62325	2nd Key Reference CPT Code: 62323
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	15.00	15.00	15.00
Median Immediate Post-service Time	6.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**40.00**	**45.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	12%	28%	60%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	44%	36%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	12%	32%	56%

Physical effort required	0%	46%	54%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	16%	48%	36%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	13%	88%	0%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	75%	13%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	25%	63%	13%
Physical effort required	0%	88%	13%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	13%	88%	0%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64446 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement))* is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these

codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64446 was previously surveyed by the RUC in 2008. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 48 responses were received from a random sample of 3,894 clinicians (1.2 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending an interim value of 1.70 wRVUs and time of pre (13/1/5), intra (15 min) and post (6 min)***. This results in an IWPUT of 0.081.

The reviewers indicated that the code was surveyed more than 75% with imaging and recommended that the code should be sent back to CPT, imaging should be bundled and the code should be re-surveyed. The specialty agrees with this recommendation and is why they are recommending an interim value for this code. The interim recommended value is less than the survey 25th percentile.

Vignette

The typical patient is described as receiving a sciatic nerve block for post-operative pain control. 92% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64446 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.80	2.19	2.33
Pre		15/4/5	
Intra	10	15	19
Post		6	

After review of the reviewer comments, ASA is reducing its original recommendation of 1.80 wRVUs to:

- wRVU
  - 1.70 wRVUs
- Time
- Pre-time: Facility pre-service package #1 -adjusted (13/1/5)
- Intra-time: 15 minutes (survey median)
- Post-time 6 minutes (survey median)

Crosswalk

The interim recommended value is based on a crosswalk. Reviewers note that the intra-service time had decreased by 5 minutes from the previous RUC survey. The Expert Panel considered these comments and selected code **10035** (*Placement of soft tissue localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including image guidance, first lesion*) which has a wRVU of 1.70, time of 20/15/10, IWPUT of 0.0733 and 2015 RUC survey.

The Expert Panel noted that it provided a reasonable increment from 64445 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single*) to account for the "continuous infusion by catheter."

The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Other Comparison Codes

The Expert Panel also considered other 0-day RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned with these codes

CPT Code	Long Desc	Global	Work RVU	Intra Time	IWPUT	2017 Utilization

53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	000	1.64	15	0.0839	1,385
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older	000	1.7	15	0.0757	148,430
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	000	1.72	15	0.0716	240
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	000	1.72	15	0.0716	2,369
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	000	1.75	15	0.0841	450,710
57410	Pelvic examination under anesthesia (other than local)	000	1.75	15	0.0345	2,420

In summary, for CPT code CPT Code 64446 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement))* ***ASA recommends 1.70 wRVUs and 19/15/6 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☒ Multiple codes are used to maintain consistency with similar codes.
   - ☒ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64446

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 17631
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 16238 Percentage 92.09 %

Specialty CRNA Frequency 829 Percentage 4.70 %

Specialty Pain Management Frequency 291 Percentage 1.65 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,877
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilizationn

Specialty Anesthesiology Frequency 5413 Percentage 92.10 %

Specialty CRNA Frequency 276 Percentage 4.69 %

Specialty Pain Management Frequency 97 Percentage 1.65 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64446

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64447 Tracking Number Original Specialty Recommended RVU: **1.40**
Presented Recommended RVU: **1.29**
Global Period: 000 Current Work RVU: **1.50** RUC Recommended RVU: **1.10**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, single

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 30-year-old male undergoes a right anterior cruciate ligament repair under general anesthesia. In order to provide postoperative pain control and increase mobility in his knee, a femoral nerve block is performed. This "block" will allow earlier discharge from the recovery room, decreased postoperative pain, and earlier ambulation.

Percentage of Survey Respondents who found Vignette to be Typical: 95%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The proposed site of the nerve block is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The skin is cleansed with an antiseptic solution and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created and placed at injection site. The skin at the proposed entry site is anesthetized with a small amount of local anesthetic via a small-gauge needle. An insulated stimulating needle is advanced through the skin in the groin. The nerve stimulator is turned on and the paitent is monitored for reports of paresthesia or appropriate muscle twitches in the quadriceps in response to nerve stimulation. The current on the nerve stimulator is reduced to confirm proximity of the needle to the femoral nerve and the needle is repositioned if necessary to maintain a muscle twitch in the appropriate distribution with a low current. Once correct needle position is obtained, aspirate the needle to confirm the absence of blood. Following negative aspiration, administer a small test-dose of local anesthetic, monitor the patient's VS, and question the patient about symptoms of intravascular local anesthetic injection. If there are no signs or symptoms of intravascular injection, inject local anesthetic in incremental doses with frequent aspiration to avoid intravascular injection. After completion of the injection, remove the needle. Observe the patient for any signs or symptoms of local anesthetic toxicity. After several minutes have passed, evaluate the initial effects of the femoral nerve block by physical examination to determine if the patient is developing weakness, numbness, and relief of pain in the expected nerve distribution.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Society of Anesthesiologists				
CPT Code:	64447				
Sample Size:	3894	**Resp N:**	62	**Response:** 1.5 %	
Description of Sample:	random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	13.00	**30.00**	60.00	1000.00
Survey RVW:	0.80	1.29	**1.51**	1.80	20.00
Pre-Service Evaluation Time:			**12.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	1.00	5.00	**6.00**	10.00	20.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64447	**Recommended Physician Work RVU: 1.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**12.00**	**13.00**	**-1.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**3.00**	**6.00**	**-3.00**
Intra-Service Time:		**6.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**18.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
23350	000	1.00	**RUC Time**	37,824

CPT Descriptor 1 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,043,217

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
62324	000	1.89	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 27 **% of respondents:** 43.5 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 12.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 64447	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: 62323
Median Pre-Service Time	16.00	15.00	20.00
Median Intra-Service Time	6.00	10.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**27.00**	**35.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	12%	58%	27%	4%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	15%	46%	39%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	19%	50%	31%
Physical effort required	12%	69%	19%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	50%	43%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	13%	63%	25%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	75%	0%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	63%	38%
Physical effort required	25%	63%	13%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	88%	13%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64447 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, single)* is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64447 was previously surveyed by the RUC in 2009. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 62 responses were received from a random sample of 3,894 clinicians (1.5 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending an interim value of 1.29 wRVUs (survey 25th) and time of pre (13/1/5), intra (6 min) and post (5 min)***. This results in an IWPUT of 0.137.

The reviewers indicated that the code was surveyed more than 75% with imaging and recommended that the code should be sent back to CPT, imaging should be bundled and the code should be re-surveyed. The specialty agrees with this recommendation and is why they are recommending an interim value for this code. The interim recommended value is less than the survey 25th percentile.

Vignette

The typical patient receives a femoral nerve block for postoperative pain control and to increase mobility in their knee. This "block" will allow earlier discharge from the recovery room, decreased postoperative pain, and earlier ambulation. 95% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64447 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.29	1.51	1.80
Pre		12/3/3	
Intra	5	6	10
Post		5	

After review of the reviewer comments, ASA is reducing its original recommendation of 1.50 wRVUs to:

- wRVU
  - 1.29 wRVU based on survey 25th percentile
- Time
  - Pre-time: Facility pre-service package #1 - adjusted (13/1/5)
  - Intra-time: 6 minutes (survey median)
  - Post-time 5 minutes (survey median)

Survey 25th Percentile

The interim recommendation of 1.29 is based on the survey 25th percentile.

Comparison Codes

The Expert Panel also identified two codes as reasonable comparisons. The Expert Panel agreed with the survey respondents that the surveyed code is more intense and complex than these comparison codes. Therefor the recommendation for a slightly higher value for the surveyed code in comparison to the reference codes seemed appropriate.

Code #	Descriptor	2018 wRVU	2018 IWPUT	Intra Time (min)	2017 Utilization
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes	1.27	0.0781	10	7,349

	imaging guidance, when performed)				
67505	Retrobulbar injection; alcohol	1.27	0.0781	10	181

In summary, for CPT code CPT Code 64447 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, single)* ***ASA recommends an interim value of 1.29 wRVUs and 19/6/5 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☒ Multiple codes are used to maintain consistency with similar codes.
   ☒ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64447

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Internal Medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 676098
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilizationn

Specialty Anesthesiology Frequency 523232 Percentage 77.38 %

Specialty CRNA Frequency 56522 Percentage 8.36 %

Specialty Internal Medicine Frequency 54967 Percentage 8.13 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 225,366 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilizationn

Specialty Anesthesiology Frequency 174411 Percentage 77.39 %

Specialty CRNA Frequency 18841 Percentage 8.36 %

Specialty Internal Medicine Frequency 18322 Percentage 8.12 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64447

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64448 Tracking Number

Original Specialty Recommended RVU: **1.78**
Presented Recommended RVU: **1.60**
RUC Recommended RVU: **1.55**

Global Period: 000 Current Work RVU: **1.63**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter replacement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 65-year-old male undergoes a right total knee replacement (CPT code 27447) under general anesthesia. The surgeon requests a block with continuous infusion to manage postoperative pain and facilitate rehabilitation. In order to provide postoperative pain control and increased mobility in his knee, a continuous femoral nerve block is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. An intravenous infusion is initiated and supplemental oxygen is provided. The site of the proposed injection is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injection is prepared. The skin is cleansed with an antiseptic solution and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created. An insulated Touhy needle is inserted through the skin and advanced towards the femoral nerve. Proper location of the needle is confirmed with the use of a nerve stimulator. A catheter is then advanced through the needle to lie next to the femoral nerve. Next, a local anesthetic is injected through the catheter with frequent aspiration and monitoring of the ECG and pulse oximeter to avoid the possibility of intravascular injection. The catheter is then secured in place and a sterile dressing is applied. Then a dilute local anesthetic infusion is initiated. Subcutaneous tunneling, affixation, and dressing of the catheter must be done carefully as this area is prone to bacterial contamination, both during and after the procedure.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018		
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)		
Specialty Society(ies):	American Society of Anesthesiologists		
CPT Code:	64448		
Sample Size:	3894	**Resp N:** 51	**Response:** 1.3 %
Description of Sample:	random		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	4.00	**20.00**	30.00	1000.00
Survey RVW:	1.00	1.78	**2.00**	2.20	12.00
Pre-Service Evaluation Time:			**14.00**		
Pre-Service Positioning Time:			**4.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	8.00	**13.00**	16.00	30.00

Immediate Post Service-Time:	**6.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64448	**Recommended Physician Work RVU: 1.55**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**13.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**6.00**	**18.00**	**-12.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62325	000	2.20	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64644	000	1.82	**RUC Time**	31,712

CPT Descriptor 1 Chemodenervation of one extremity; 5 or more muscles

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,043,217

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
62324	000	1.89	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 23 **% of respondents:** 45.0 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 23.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 64448	Top Key Reference CPT Code: 62325	2nd Key Reference CPT Code: 62323
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	13.00	15.00	15.00
Median Immediate Post-service Time	6.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**38.00**	**45.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	4%	30%	61%	4%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	22%	35%	43%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	4%	35%	61%

Physical effort required	5%	45%	50%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	22%	30%	48%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	18%	73%	9%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	27%	45%	27%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	27%	55%	18%
Physical effort required	9%	73%	18%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	27%	64%	9%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64448 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter replacement))* is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around

the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64448 was previously surveyed by the RUC in 2008. It was surveyed for the October 2018 RUC meeting by the American Society for Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 51 responses were received from a random sample of 3,894 clinicians (1.3 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending an interim value of 1.60 wRVUs and time of pre (13/1/5), intra (13 min) and post (6 min)***. This results in an IWPUT of 0.086.

The reviewers indicated that the code was surveyed more than 75% with imaging and recommended that the code should be sent back to CPT, imaging should be bundled and the code should be re-surveyed. The specialty agrees with this recommendation and is why they are recommending an interim value for this code. The interim recommended value is less than the survey 25th percentile and the current value of 1.63 wRVUs.

Vignette

The typical patient femoral nerve block to manage postoperative pain and facilitate rehabilitation after a total knee replacement. 88% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64448 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.78	2.00	2.20
Pre		14/4/5	
Intra	8	13	16
Post		6	

- **After review of the reviewer comments, ASA is reducing its original recommendation of 1.78 wRVUs to:**
- wRVU
  - 1.60 wRVU; this recommendation is less than the survey 25th percentile of 1.78 wRVUs and just slightly less than the current value of 1.63 wRVUs
- Time
  - Pre-time: Facility pre-service package #1 - adjusted (13/1/5)
  - Intra-time: 13 minutes (survey median)
  - Post-time 6 minutes (survey median)

Crosswalk

The interim recommended value is based on a crosswalk. Reviewers note that the intra-service time had decreased by 2 minutes from the previous RUC survey. The Expert Panel considered these comments and selected code **64488** (*Transversus abdominis plane (TAP) (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance when performed*) which has a wRVU of 1.60, time of 20/15/10, IWPUT of 0.0733 and 2015 RUC survey.

The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

In summary, for CPT code CPT Code 64448 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter replacement))* ***ASA recommends 1.60 wRVUs and 19/13/6 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☒ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☒ Multiple codes are used to maintain consistency with similar codes.
   - ☒ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. CPT code 76942-26 (Global: XXX; wRVUs: 0.67; Time: 7/15/5)

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64448

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty CRNA How often? Commonly

Specialty Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 128265
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 114566 Percentage 89.31 %

Specialty CRNA Frequency 12172 Percentage 9.48 %

Specialty Pain Management Frequency 834 Percentage 0.65 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 42,755 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology Frequency 38189 Percentage 89.32 %

Specialty CRNA Frequency 4057 Percentage 9.48 %

Specialty Pain management Frequency 278 Percentage 0.65 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64448

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64449 Tracking Number Original Specialty Recommended RVU: **1.80**
Presented Recommended RVU: **1.70**
Global Period: 000 Current Work RVU: **1.81** RUC Recommended RVU: **1.55**

CPT Descriptor: injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 62-year-old female undergoes a left total knee replacement (CPT code 27447) under general anesthesia. The surgeon requests a block with a continuous infusion to manage post-operative pain and facilitate rehabilitation. In order to provide post-operative pain control and increased mobility in her knee, a continuous lumbar plexus block is performed.

Percentage of Survey Respondents who found Vignette to be Typical: 61%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. An intravenous infusion is initiated and supplemental oxygen is provided. The site of the proposed injection is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The low back is prepped with a topical antiseptic and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created and placed at injection site. After infiltrating the skin and deeper tissues with local anesthetic using a small gauge needle, a Touhy needle designed to allow the introduction of a catheter is connected to a peripheral nerve stimulator and advanced to obtain stimulation of the lumbar plexus. At this point careful aspiration for blood and CSF is performed. A test dose of local anesthetic is administered to rule out IV or intrathecal injection. Between 15 and 30 ml of dilute local anesthetic is slowly injected through the needle, followed by insertion of an infusion catheter through the needle (about 5 cm past the tip of the needle). The patient is observed for signs of undesired epidural spread and associated hemodynamic changes, and for analgesia of the left leg and hip. The catheter is checked for intravascular and intrathecal placement and secured in place. Once correct function of the catheter is confirmed, a continuous infusion of a dilute local anesthetic is started.

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018				
Presenter(s):	Neal Cohen, MD (ASA); Marc Leib, MD (ASA); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Society of Anesthesiologists				
CPT Code:	64449				
Sample Size:	3894	**Resp N:**	36	**Response:** 0.9 %	
Description of Sample:	random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	9.00	1000.00
Survey RVW:	1.00	1.80	**2.20**	2.41	12.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	8.00	**14.00**	20.00	30.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64449	**Recommended Physician Work RVU: 1.55**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**14.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**18.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62325	000	2.20	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
62323	000	1.80	**RUC Time**

CPT Descriptor Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64644	000	1.82	**RUC Time**	31,712

CPT Descriptor 1 Chemodenervation of one extremity; 5 or more muscles

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64483	000	1.90	**RUC Time**	1,043,217

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

Other Reference CPT Code	Global	Work RVU	Time Source
62324	000	1.89	**RUC Time**

CPT Descriptor Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 **% of respondents:** 50.0 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 22.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 64449	Top Key Reference CPT Code: 62325	2nd Key Reference CPT Code: **62323**
Median Pre-Service Time	19.00	20.00	20.00
Median Intra-Service Time	14.00	15.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**38.00**	**45.00**	**45.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	6%	29%	41%	24%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	12%	41%	47%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	6%	29%	65%

Physical effort required	0%	47%	53%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	18%	29%	53%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	75%	13%	13%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	43%	57%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	43%	57%
Physical effort required	0%	71%	2900%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	57%	43%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64449 (*Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency

around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64449 was previously surveyed by the RUC in 2008. It was surveyed for the October 2018 RUC meeting by the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 36 responses were received from a random sample of 3,894 clinicians (0.90 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending a value of 1.70 wRVUs and time of pre (13/1/5), intra (14 min) and post (5 min)***. This results in an IWPUT of 0.088.

Vignette

The typical patient received a lumbar plexus block after knee surgery for post-operative pain management and to facilitate rehabilitation. 61% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64449 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.80	2.20	2.41
Pre		15/5/5	
Intra	8	14	20
Post		5	

After review of the reviewer comments, ASA is reducing its original recommendation of 1.80 wRVUs to:

- wRVU
  - 1.70 wRVU; this is less than the survey 25h percentile of 1.80 wRVUs and less than the current value of 1.81 wRVUs
- Time
  - Pre-time: Facility pre-service package #1 - adjusted (13/1/5)
  - Intra-time: 14 minutes (survey median)
  - Post-time 5 minutes (survey median)

Currently code 64446 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)* and code 64449 have the same value. This recommendation maintains the same value for both codes. Both codes also had similar survey times, providing evidence of the appropriateness of maintaining that relationship.

Crosswalk

The interim recommended value is based on a crosswalk. The Expert Panel selected code **10035** (*Placement of soft tissue localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including image guidance, first lesion*) which has a wRVU of 1.70, time of 20/15/10, IWPUT of 0.0733 and 2015 RUC survey.

The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Other Comparison Codes

The Expert Panel also considered other 0-day RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned with these codes.

CPT Code	Long Desc	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
53855	Insertion of a temporary prostatic urethral stent, including urethral measurement	000	1.64	15	0.0839	1,385

36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older	000	1.7	15	0.0757	148,430
43201	Esophagoscopy, flexible, transoral; with directed submucosal injection(s), any substance	000	1.72	15	0.0716	240
43202	Esophagoscopy, flexible, transoral; with biopsy, single or multiple	000	1.72	15	0.0716	2,369
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	000	1.75	15	0.0841	450,710
57410	Pelvic examination under anesthesia (other than local)	000	1.75	15	0.0345	2,420

In summary, for CPT code CPT Code 64449 (*Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)*) ***ASA recommends 1.70 wRVUs and 19/14/5 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64449

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Neurology How often? Commonly

Specialty Family Practice How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 6984
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 5826 Percentage 83.41 %

Specialty Neurology Frequency 372 Percentage 5.32 %

Specialty Family Practice Frequency 168 Percentage 2.40 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,328
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology Frequency 1942 Percentage 83.41 %

Specialty Neurology Frequency 124 Percentage 5.32 %

Specialty Family Practice Frequency 56 Percentage 2.40 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64449

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64450 Tracking Number Original Specialty Recommended RVU: **0.84**
Presented Recommended RVU: **0.84**
Global Period: 000 Current Work RVU: **0.75** RUC Recommended RVU: **0.75**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old female complains of chronic burning pain and a tingling sensation in the plantar aspect of her right foot. Clinical examination is consistent with tarsal tunnel syndrome. The decision is made to perform a therapeutic injection about the posterior tibial nerve utilizing local anesthetic and a steroid.

Percentage of Survey Respondents who found Vignette to be Typical: 78%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The site of the proposed injection is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injectate is prepared. The skin is cleansed with an antiseptic solution and sterile drapes are applied. A universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. A local anesthetic skin wheal is created and placed at injection site. Palpate the posterior tibial artery. Direct the needle slightly posterior and inferior to the posterior tibial artery. Prior to injecting, aspirate the needle to ensure that vascular structures are not injected. Redirect the needle proximally and distally and repeat aspiration and injection. The needle is removed, and the site is observed for bleeding and covered with a sterile occlusive dressing. .

Description of Post-Service Work: The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2018					
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Kevin Kerber, MD (AAN); Marc Leib, MD (ASA); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA); Raissa Villanueva, MD (AAN)					
Specialty Society(ies):	American Academy of Neurology; American Academy of Pain Medicine; American Academy of Physical Medicine and Rehabilitation; American Society of Anesthesiologists					
CPT Code:	64450					
Sample Size:	3256	**Resp N:**	88	**Response:** 2.7 %		
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	12.00	**26.00**	60.00	1475.00	
Survey RVW:	0.50	1.00	**1.34**	1.80	6.50	
Pre-Service Evaluation Time:			**21.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**5.00**			
Intra-Service Time:	1.00	5.00	**10.00**	15.00	45.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64450	**Recommended Physician Work RVU: 0.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**7.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**1.00**	**1.00**	**0.00**
Intra-Service Time:		**5.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**18.00**	**-13.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64493	000	1.52	**RUC Time**

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20553	000	0.75	**RUC Time**	346,970

CPT Descriptor 1 Injection(s); single or multiple trigger point(s), 3 or more muscles

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
23350	000	1.00	**RUC Time**	37,824

CPT Descriptor 2 Injection procedure for shoulder arthrography or enhanced CT/MRI shoulder arthrography

Other Reference CPT Code	Global	Work RVU	Time Source
20526	000	0.94	**RUC Time**

CPT Descriptor Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 20 **% of respondents:** 22.7 **%**

Number of respondents who choose 2nd Key Reference Code: 18 **% of respondents:** 20.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 64450	Top Key Reference CPT Code: 64486	2nd Key Reference CPT Code: 64493
Median Pre-Service Time	9.00	15.00	17.00
Median Intra-Service Time	5.00	10.00	15.00
Median Immediate Post-service Time	5.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**19.00**	**35.00**	**42.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	63%	32%	5%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	60%	30%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	5%	80%	15%
Physical effort required	0%	85%	15%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	65%	25%

2nd Key Reference Code

	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	56%	33%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	72%	11%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	61%	28%
Physical effort required	6%	59%	35%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	83%	11%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT Code 64450 (*Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch*) is part of Tab 9 which includes changes and revisions to the Somatic Nerve Injection family (codes 64400- 64450). CPT staff, at the request of the Editorial Board of the *CPT Assistant*, reached out to several specialties to request a code change application to provide further definition and descriptor transparency around the use of these codes. The new code family was approved at the May 2018 CPT Editorial Panel meeting and surveyed for the October 2018 RUC meeting.

Code 64450 was previously surveyed by the RUC in 2011. It was surveyed for the October 2018 RUC meeting by the American Academy of Neurology (AAN), the American Academy of Pain Medicine (AAPM), the American Academy of Physical Medicine & Rehabilitation (AAPM&R) and the American Society of Anesthesiologists (ASA).

October 2018 RUC Meeting Recommendation Rationale

A total of 88 responses were received from a random sample of 3,256 clinicians (2.7 percent response rate). ASA convened an Expert Panel to review the survey data. ***The society is recommending 0.84 wRVUs and time of pre (7/0/1), intra (10 min) and post (5 min)***. This results in an IWPUT of 0.056.

Vignette

The vignette describes a typical patient experiencing a chronic burning pain and a tingling sensation in the plantar aspect of her right foot. Clinical examination is consistent with tarsal tunnel syndrome. The decision is made to perform a therapeutic injection about the posterior tibial nerve utilizing local anesthetic and a steroid.

78% of the survey respondents found the vignette to be typical.

Survey Data: wRVU and Time

The Expert Panel reviewed the survey data.

64450 Highlights from Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.00	1.34	1.80
Pre		21/5/5	
Intra	5	10	15
Post		5	

The survey 25th percentile is higher than the current value of 0.75 wRVUs. The Expert Panel considered recommending the 25th percentile which they felt to be approximating a reasonable value for the service. They also noted that the intra-time doubled from 5 minutes to 10 minutes since the last survey. The Expert Panel concluded that this increase in intra-time supported a higher wRVU.

After a robust discussion the Expert Panel agreed to recommend:

- wRVU
  - 0.84 work RVUs based on a crosswalk to code 12001
- Time
  - Pre-time: Non-facility pre-service package #5 (7/0/1)
  - Intra-time: 10 minutes (survey median)
  - Post-time 5 minutes (survey median)

The Expert Panel discussed how in general the treatment for pain conditions has become more complex as the opioid crisis has escalated, and treatment and coverage for other non-pharmacologic and non-interventional strategies has been limited. With worsening pain, this impacts mobility, and in general has led to a more sedentary population with increase in co-morbidities of diabetes, hypertension and obesity. These findings, particularly the increase in BMI, have led to increases in the technical skill and judgment necessary to perform the procedure as well as the associated psychological stress to reduce risk of complications, such as pneumothorax or intravascular complication.

The Expert Panel concluded that these values and times appropriately reflected how the service is currently performed. In drafting their recommendations, the Expert Panel considered a number of factors.

Crosswalk

- The Expert Panel selected a value that was less than the survey 25th percentile of 1.00 wRVUs; crosswalking the recommendation of 0.84 wRVUs to code 12001 (*Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less*). This 0-day global code was reviewed by the RUC in 2010 and also has 10 minutes intra-service. It has an IWPUT of 0.0585. The Expert Panel believes that this is an appropriate crosswalk not only because it matches intra-service time but also because of similarity in complexity and intensity. The Expert Panel does believe that the surveyed code 64450 is a somewhat more intense/complex than 12001.

Reference Code

- The Expert Panel also concluded that the recommendation aligned well with the top reference code 64486 (*Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)*) which has a wRVU of 1.27, IWPUT of 0.0781 and intra time of 10 minutes. The Expert Panel noted that the codes had the same intra time and the reference code had a slightly higher IWPUT. The recommended value represents an appropriate rank order and alignment.

Other Codes in the Somatic Nerve Injection Family

- The Expert Panel also concluded the recommendation maintained rank order in the Somatic Nerve Injection family.

Code#	Description	Proposed wRVU
+64421	N block inj intercost sng, addl level	0.60
64435	N block inj paracervical	0.75
64450	**N block other peripheral**	**0.84**
64405	N block inj occipital	0.94
64408	N block inj vagus	0.94
64418	N block inj suprascapular	1.10
64400	N block inj trigeminal	1.14
64430	N block inj pudendal	1.15
64425	N block inj ilio-ing/hypogi	1.19
64420	N block inj intercost sng	1.24
64417	N block inj axillary	1.27
64447	N block inj fem single	1.40
64415	N block inj brachial plexus	1.42
64445	N block inj sciatic sng	1.47
64448	N block inj fem cont inf	1.78
64446	N blk inj sciatic cont inf	1.80
64449	N block inj lumbar plexus	1.80
64416	N block cont infuse b plex	1.81

Rank Order

- The Expert Panel also considered other 0-day, RUC reviewed codes outside of the Somatic Nerve Injection family with similar intra-time and concluded that the recommendation aligned well with these codes and provided further evidence of the appropriateness of the recommendation.

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
20553	Injection(s); single or multiple trigger point(s), 3 or more muscles	000	0.75	10	0.0441	346,970
20610	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance	000	0.79	5	0.1006	681,9323
11901	Injection, intralesional;	000	0.80	13	0.046	69,094

CPT Code	Long Descriptor	Global	Work RVU	Intra Time	IWPUT	2017 Utilization
	more than 7 lesions					
11100	Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion	000	0.81	12	0.0488	3,646,411
69100	Biopsy external ear	000	0.81	12	0.0451	155,215
69220	Debridement, mastoidectomy cavity, simple (eg, routine cleaning)	000	0.83	10	0.0651	52,818
64450	**Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch**	**000**	**0.84**	**10**	**0.056**	**413,282**
65222	Removal of foreign body, external eye; corneal, with slit lamp	000	0.84	7	0.0944	27,017
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	000	0.84	10	0.0585	189,564
45330	Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)	000	0.84	10	0.0217	54,322
11950	Subcutaneous injection of filling material (eg, collagen); 1 cc or less	000	0.84	15	0.0261	7
51720	Bladder instillation of anticarcinogenic agent (including retention time)	000	0.87	5	0.1199	192,279
20604	Arthrocentesis, aspiration and/or injection, small joint or bursa (eg, fingers, toes); with ultrasound guidance, with permanent recording and reporting	000	0.89	10	0.0581	40,141
57160	Fitting and insertion of pessary or other intravaginal support device	000	0.89	15	0.0268	90,878

In summary, for CPT code CPT Code 64450 (*Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch*) ***the societies recommend 0.84 wRVUs and 8/10/5 for time.***

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64450

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology	How often? Commonly
Specialty Nurse Practitioners	How often? Commonly
Specialty Pain Management	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 945589
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology	Frequency 248974	Percentage 26.33 %
Specialty Nurse Practitioners	Frequency 122927	Percentage 13.00 %
Specialty Pain Management	Frequency 115646	Percentage 12.23 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 378,236 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology	Frequency 99589	Percentage 26.32 %
Specialty Nurse Practitioners	Frequency 49171	Percentage 13.00 %

Specialty Pain Management Frequency 46258 Percentage 12.22 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64450

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

SS Rec Summary

ISSUE: Somatic Nerve Injection (as revised 10/6/2018)

TAB: 9

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	11	0.107			2.20			45	10	5	5			15			10																							
2nd REF	64644	Chemodenervation of one extremity; 5 or more muscles	8	0.055			1.82			45	10	5				25			5																							
CURRENT	64400	Injection, anesthetic agent; trigeminal nerve, any division or branch		0.011			1.11			69	16					37			16																							
SVY	64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	56	0.048	0.50	1.14	1.50	2.20	15.00	53	18	5	5	1	5	15	20	60	10																				0	2	10	50	500
SVY- ASA	64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	31	0.075	0.65	1.46	2.10	2.35	15.00	62	22	5	5	1	14	15	20	60	15																				0	2	5	15	50
SVY- AAN	64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)	25	0.141	0.50	1.00	1.25	1.50	2.50	26	8	3	3	2	5	6	10	20	6																				0	6	61	100	500
REC	64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)		0.117	1.00					20	7	1	1			6			5																							

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	20556	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	92	0.139			0.94			16	6					5			5																							
2nd REF	20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	19	0.075			0.66			21	5	1	5			5			5																							
CURRENT	64405	Injection, anesthetic agent; greater occipital nerve		0.112			0.94			16	6					5			5																							
SVY (April 2017)	64405	Injection, anesthetic agent; greater occipital nerve	3856	0.132	0.50	0.94	1.00	1.29	14.00	22	6	3	3			5			5																				0	12	25	50	500
REC	64405	Injection, anesthetic agent; greater occipital nerve		0.139	0.94					16	5	1				5			5																							

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	20552	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	7	0.075			0.66			21	5	1	5			5			5																							
2nd REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	5	0.078			1.27			35	5	5	5			10			10																							
CURRENT	64408	Injection, anesthetic agent; vagus nerve		0.060			1.41			36	10					16			10																							
SVY	64408	Injection, anesthetic agent; vagus nerve	37	0.112	0.75	0.90	1.25	1.90	11.00	37	21	3	2	2	3	5	10	45	6																				0	2	5	15	100
REFERENCE	31575	Laryngoscopy, flexible; diagnostic		0.1172	0.94					19	5	1	3			5			5																							
REC	64408	Injection, anesthetic agent; vagus nerve		0.113	0.90					20	7	3				5			5																							

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
44	1st REF	62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	13	0.080			1.80			45	10	5	5			15			10																								
45	2nd REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	11	0.078			1.27			35	5	5	5			10			10																								
46	CURRENT	64415	Injection, anesthetic agent; brachial plexus, single		0.060			1.48			44	13	1	5			15			10																								
47	SVY	64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single	57	0.076	0.70	1.42	1.70	2.00	10.00	50	20	4	4	1	8	12	15	60	10																					0	5	25	76	600
48	REC	64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single		0.071			1.42			40	13	1	4			12			10																								
49																																												
50						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
51	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
52	1st REF	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	26	0.107			2.20			45	10	5	5			15			10																								
53	2nd REF	62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	9	0.080			1.80			45	10	5	5			15			10																								
54	CURRENT	64416	Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)		0.049			1.81			60	19	1	5			20			15																								
55	SVY	64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)	42	0.055	1.00	1.81	2.10	2.20	12.00	68	23	5	5	1	15	20	24	60	15																					0	2	18	43	400
56	REC	64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement)		0.062			1.81			49	13	1	5			20			10																								
57											0																																	
58	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
59	1st REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	15	0.078			1.27			35	5	5	5			10			10																								
60	2nd REF	62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	8	0.080			1.80			45	10	5	5			15			10																								
61	CURRENT	64417	Injection, anesthetic agent; axillary nerve		0.045			1.44			45	13					19			13																								
62	SVY	64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve	45	0.068	0.68	1.27	1.50	2.00	12.00	49	21	4	4	1	5	10	18	35	10																					0	2	6	12	500
63	REC	64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve		0.070			1.27			38	13	1	4			10			10																								
64																																												
65						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
66	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
67	1st REF	64450	Injection, anesthetic agent; other peripheral nerve or branch	39	0.083			0.75			20	10					5			5																								
68	2nd REF	12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	31	0.064			1.22			27	5	1	1			15			5																								
69	CURRENT	64418	Injection, anesthetic agent; suprascapular nerve		0.065			1.10			32	6	3	3			10			10																								
70	SVY (April - 2016)	64418	Injection, anesthetic agent; suprascapular nerve	139	0.045	0.70	1.00	1.20	1.45	4.00	47	17	5	5	1	5	10	13	45	10																					0	3	7	20	1300

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
71	Crosswalk	20611	Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting		0.079			1.10				5	2	5			10			5																							
72	REC	64418	Injection, anesthetic agent; suprascapular nerve		0.065			1.10			32	6	3	3			10			10																							
73																																												
74						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
75	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
76	1st REF	64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	23	0.066			1.52			42	7	5	5			15			10																							
77	2nd REF	64483	Injection(s), anesthetic agent andor steroid, transforaminal epidural, with imaging guidance (fluroscopy or CT); lumbar or sacral, single level	13	0.082			1.90			49	13	5	6			15			10																							
78	CURRENT	64420	Injection, anesthetic agent; intercostal nerve, single		0.043			1.18			37	10					17			10																							
79	SVY	64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	60	0.056	0.75	1.24	1.50	1.86	30.00	55	25	5	5	1	8	10	15	30	10																						0	2	10	25	500
80	SVY- ASA	64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	25	0.114	1.52	1.74	1.92	2.11	30.00	48	18	5	5	1	7	10	15	30	10																						0	2	5	20	25
81	SVY- AAPM&R	64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	15	0.041	1.30	1.40	1.50	1.50	1.52	58	23	5	5	5	9	15	20	28	10																						0	5	20	39	100
82	SVY- AAPM	64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level	20	0.024	0.75	1.00	1.20	1.23	1.30	56	25	5	5	5	8	10	15	20	11																						0	2	23	35	500
83	Crosswalk	67810	Incisional biopsy of eyelid skin including lid margin		0.069			1.18			27	8	1	2			13			3																							
84	REC	64420	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level		0.071			1.18			34	13	1	5			10			5																							
85																																												
86						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
87	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
88	1st REF	64462	Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)	17	0.073			1.10			15						15																									
89	2nd REF	64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)	13	0.100			1.00			10						10																									
90	CURRENT	64421	Injection, anesthetic agent; intercostal nerves, multiple, regional block		0.029			1.68			65	15					35			15																							
91	SVY	64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)	60	0.124	0.60	1.00	1.24	1.50	30.00	10				1	8	10	15	35																						0	2	10	21	500
92	SVY- ASA	64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)	25	0.127	0.60	1.00	1.27	1.50	30.00	10				1	7	10	15	22																						0	0	4	25	500
93	SVY- AAPM&R	64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)	15	0.140	0.80	1.10	1.40	1.74	10.00	10				5	10	10	15	35																						0	3	10	18	50
94	SVY- AAPM	64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)	20	0.116	0.60	0.98	1.16	1.28	2.50	10				3	7	10	15	20																						0	10	20	21	50
95	Crosswalk	77063	Screening digital breast tomosynthesis, bilateral (List separately in addition to code for primary procedure)		0.075			0.60			8						8																									
96	REC	64421	Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)		0.060			0.60			10						10																									
97																																												

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
98						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
99	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
100	1st REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	25	0.078			1.27			35	5	5	5			10			10																								
101	2nd REF	64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	8	0.066			1.52			42	7	5	5			15			10																								
102	CURRENT	64425	Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves		0.093			1.75			31	8					15			8																								
103	SVY	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	54	0.035	0.84	1.19	1.30	1.59	30.00	55	24	5	5	1	10	11	15	31	10																						0	3	8	23	500
104	SVY- ASA	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	26	0.051	0.92	1.05	1.30	1.56	30.00	47	20	5	5	1	10	11	15	30	6																						0	0	6	15	500
105	SVY- AAPM&R	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	11	0.023	1.00	1.20	1.50	1.83	2.00	70	30	5	5	5	11	20	20	31	10																						0	3	6	15	50
106	SVY- AAPM	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves	17	0.038	0.84	1.20	1.27	1.50	1.90	53	23	5	5	3	9	10	12	25	10																						3	5	12	25	50
107	REC	64425	Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves		0.081			1.19			25	7	1	1			11			5																								
108																																												
109						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
110	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
111	1st REF	64644	Chemodenervation of one extremity; 5 or more muscles	9	0.055			1.82			45	10	5	0			25			5																								
112	2nd REF	62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	8	0.080			1.80			45	10	5	5			15			10																								
113	CURRENT	64430	Injection, anesthetic agent; pudendal nerve		0.057			1.46			39	11					17			11																								
114	SVY	64430	Injection, anesthetic agent(s) and/or steroid; pudendal nerve	67	0.063	0.10	1.15	1.50	1.89	3.60	52	22	5	5	1	5	10	15	35	10																						0	2	5	18	500
115	SVY- ASA	64430	Injection, anesthetic agent(s) and/or steroid; pudendal nerve	31	0.054	1.00	1.30	1.52	1.84	3.00	54	22	5	5	1	10	12	15	30	10																						*0*	*2*	*6*	*20*	*500*
116	SVY- AAPM	64430	Injection, anesthetic agent(s) and/or steroid; pudendal nerve	9	0.063	0.80	1.38	1.80	2.00	2.50	62	29	5	5	5	10	12	18	35	11																						*5*	*7*	*12*	*50*	*250*
117	SVY- ACOG	64430	Injection, anesthetic agent(s) and/or steroid; pudendal nerve	27	0.043	0.70	0.84	1.20	1.80	3.60	48	22	5	3	1	5	8	10	30	10																						*0*	*1*	*3*	*6*	*50*
118	REC	64430	Injection, anesthetic agent(s) and/or steroid; pudendal nerve		0.048			1.15			43	13	5	5			10			10																								
119																																												
120						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
121	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
122	1st REF	20551	Injection(s); single tendon origin/insertion	12	0.083			0.75			20	10					5			5																								
123	2nd REF	57500	Biopsy of cervix, single or multiple, or local excision of lesion, with or without fulguration (separate procedure)	11	0.060			1.20			29	7	1	1			15			5																								
124	CURRENT	64435	Injection, anesthetic agent; paracervical (uterine) nerve		0.064			1.45			33	8					17			8																								
125	SVY	64435	Injection, anesthetic agent(s) and/or steroid; paracervical (uterine) nerve	42	0.115	0.60	0.75	1.00	1.20	2.75	26	10	3	3	1	3	5	10	30	5																						0	5	18	50	500
126	REC	64435	Injection, anesthetic agent(s) and/or steroid; paracervical (uterine) nerve		0.083			0.75			20	7	3	0			5			5																								
127																																												
128						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
129	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
130	1st REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	19	0.078			1.27			35	5	5	5			10			10																								

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
131	2nd REF	64483	Injection(s), anesthetic agent andor steroid, transforaminal epidural, with imaging guidance (fluroscopy or CT); lumbar or sacral, single level	10	0.082			1.90			49	13	5	6			15			10																							
132	CURRENT	64445	Injection, anesthetic agent; sciatic nerve, single		0.054			1.48			48	13	5	5			15			10																							
133	SVY	64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single	68	0.093	0.80	1.30	1.51	1.83	10.00	38.5	15	3.5	4	1	6	10	13	30	6																					0	10	25	51	1000
134	SVY- ASA	64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single	57	0.114	0.88	1.35	1.52	1.90	10.00	33	13	3	3	1	6	9	10	20	5																					0	12	30	85	1000
135	SVY- AAPM&R	64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single	11	0.012	0.80	1.24	1.40	1.59	1.92	75	30	5	5	3	8	20	20	30	15																					0	1	12	20	52
136	Crosswalk	67810	Incisional biopsy of eyelid skin including lid margin		0.069			1.18			27	8	1	2			13			3																							
137	REC	64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single		0.088			1.18			24	7	1	1			10			5																							
138																																												
139						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
140	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
141	1st REF	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	26	0.107			2.20			45	10	5	5			15			10																							
142	2nd REF	62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	8	0.080			1.80			45	10	5	5			15			10																							
143	CURRENT	64446	Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)		0.045			1.81			64	19	5	5			20			15																							
144	SVY	64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)	48	0.106	1.00	1.80	2.19	2.33	10.00	45	15	4	5	1	10	15	19	30	6																					0	4	20	37	1000
145	Crosswalk	30903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method		0.072			1.54			39	8	1	5			15			10																							
146	REC	64446	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement)		0.070			1.54			40	13	1	5			15			6																							
147																																												
148						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
149	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
150	1st REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	27	0.078			1.27			35	5	5	5			10			10																							
151	2nd REF	62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	8	0.080			1.80			45	10	5	5			15			10																							
152	CURRENT	64447	Injection, anesthetic agent; femoral nerve, single		0.061			1.50			44	13	1	5			15			10																							
153	SVY	64447	Injection(s), anesthetic agent(s) and/or steroid;femoral nerve, single	62	0.173	0.80	1.29	1.51	1.80	20.00	29	12	3	3	1	5	6	10	20	5																					0	13	30	60	1000
154	Crosswalk	31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)					1.10			21	5	1	5			7			3																							
155	REC	64447	Injection(s), anesthetic agent(s) and/or steroid;femoral nerve, single		0.112			1.10			27	12	1	3			6			5																							
156																																												
157						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
158	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
159	1st REF	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	23	0.107			2.20			45	10	5	5			15			10																								
160	2nd REF	62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	12	0.080			1.80			45	10	5	5			15			10																								
161	CURRENT	64448	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)		0.054			1.63			55	19	1	5			15			15																								
162	SVY	64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)	51	0.109	1.00	1.78	2.00	2.20	12.00	42	14	4	5	1	8	13	16	30	6																						0	4	20	30	1000
163	Crosswalk	62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance		0.090			1.55			39	10	3	5			11			10																								
164	REC	64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement)		0.082			1.55			38	13	1	5			13			6																								
165																																												
166						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
167	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
168	1st REF	62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	18	0.107			2.20			45	10	5	5			15			10																								
169	2nd REF	62323	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	8	0.080			1.80			45	10	5	5			15			10																								
170	CURRENT	64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)		0.049			1.81			60	19	5	5			20			11																								
171	SVY	64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)	36	0.114	1.00	1.80	2.20	2.41	12.00	44	15	5	5	1	8	14	20	30	5																						0	0	2	9	1000
172	Crosswalk]	62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance		0.090			1.55			39	10	3	5			11			10																								
173	REC	64449	Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)		0.077			1.55			38	13	1	5			14			5																								
174																																												
175						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
176	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
177	1st REF	64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	20	0.078			1.27			35	5	5	5			10			10																								
178	2nd REF	64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	18	0.066			1.52			42	7	5	5			15			10																								
179	CURRENT	64450	Injection, anesthetic agent; other peripheral nerve or branch		0.083			0.75			20	10					5			5																								
180	SVY	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	88	0.061	0.50	1.00	1.34	1.80	6.50	46	21	5	5	1	5	10	15	45	5																						0	12	26	60	1475

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS
15						RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
16	Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
181	SVY- ASA	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	29	0.064	0.50	1.25	1.35	1.84	6.50	45	20	5	5	1	6	10	15	30	5																				0	10	25	60	400
182	SVY- AAPM&R	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	15	0.084	0.75	1.10	1.60	1.82	2.00	47	20	5	5	1	9	10	19	45	7																				0	11	30	50	200
183	SVY- AAPM	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	17	0.035	0.68	0.90	1.33	1.80	4.00	56	23	5	5	2	10	12	15	25	11																				5	25	30	50	400
184	SVY- AAN	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	27	0.084	0.55	0.93	1.15	1.50	2.00	34	13	5	3	1	5	7	10	20	6																				1	8	20	95	1475
185	Crosswalk	20553	Injection(s); single or multiple trigger point(s), 3 or more muscles		0.044			0.75			27	5	2	5			10			5																								
186	REC	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		0.090			0.75			19	7	1	1			5			5																								
187																																												
188																																												

CPT Code:___64400_____
Specialty Society_____AAN, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)

Global Period:__0___ Meeting Date: __October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64400 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

   Is this code(s) typically billed with the E/M service in the nonfacility?
   (Please see provided data in PE Subcommittee folder)

   No it is billed with an E/M office visit 32% of the time.

4. What specialty is the dominant provider in the nonfacility? *Neurology – 59%*
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? *67%*
   Is the dominant provider in the nonfacility different then for the global? *No.*
   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

   We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are

not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:

   N/A

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code). *5 minutes*
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

    N/A

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

    N/A

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

    N/A

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

    N/A

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Table, exam - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here: *Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).*

18. Please include an explanation of each line item:

Code	Supply	64400
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Skribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SC028	needle, 18-26g 1.5-3.5in, spinal	For performing the procedure
SH021	bupivacaine 0.25% inj (Marcaine)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

CPT Code:___64415_____
Specialty Society_____ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single

Global Period:__0___ Meeting Date: __October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64415 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

   Is this code(s) typically billed with the E/M service in the nonfacility?
   (Please see provided data in PE Subcommittee folder)

   No it is billed with an E/M office visit 1% of the time.

4. What specialty is the dominant provider in the nonfacility? *Neurology – 34%*
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? *This service is provided in the non-facility setting 2% of the time.*
   Is the dominant provider in the nonfacility different then for the global? *Yes. For the global, the dominant specialty is Anesthesiology (87%)*
   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

   We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Table, exam – default
    Nerve stimulator (eg, for nerve block) – default
    ECG, 3-channel (with SpO2, NIBP, temp, respt) – default
    Mayo stand - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here:
Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).

18. Please include an explanation of each line item:

Code	Supply	64415
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Skribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC038	needle, epidural (RK)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SD269	Grounding pad	For performing the procedure
SB019	drape-towel, sterile 18in x 26in	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; axillary nerve

Global Period:__0___ Meeting Date: __October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64417 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

   Is this code(s) typically billed with the E/M service in the nonfacility?
   (Please see provided data in PE Subcommittee folder)

   No it is billed with an E/M office visit 2% of the time.

4. What specialty is the dominant provider in the nonfacility? *Neurology – 48%*
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? *This service is provided in the non-facility setting less than 10% of the time.*

   Is the dominant provider in the nonfacility different then for the global? *For the global, the dominant specialty is Anesthesiology (79%)*

   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

   We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are

not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

    Table, exam – default
    Nerve stimulator (eg, for nerve block) – default
    Mayo stand - default

17. If there is any other item on your spreadsheet that needs further explanation please include here:
Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).

18. Please include an explanation of each line item:

Code	Supply	64417
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Skribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH021	bupivacaine 0.25% inj (Marcaine)	For performing the procedure
SD050	electrode needle, injectable (Myoject)	For performing the procedure
SC038	needle, epidural (RK)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

CPT Code:___64420_____
Specialty Society_____AAPM, AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level

Global Period:__0___ Meeting Date: __October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64420 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

   Is this code(s) typically billed with the E/M service in the nonfacility?
   (Please see provided data in PE Subcommittee folder)

   No it is billed with an E/M office visit 38% of the time.

4. What specialty is the dominant provider in the nonfacility? *Interventional Pain Management – 17%*
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? *47%*
   Is the dominant provider in the nonfacility different then for the global? *For the global, the dominant specialty is Anesthesiology (40%)*

   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

   N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Table, exam – default
    Mayo stand - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here: *Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).*

18. Please include an explanation of each line item:

Code	**Supply**	**64420**

SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Skribe)	For performing the procedure
SC034	needle, blunt tip	For performing the procedure
SJ053	swab-pad, alcohol	For performing the procedure
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC051	syringe 10-12ml	For performing the procedure

CPT Code:___64421_____
Specialty Society_____AAPM, AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)

Global Period:__0___ Meeting Date: __October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64421 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

   Is this code(s) typically billed with the E/M service in the nonfacility?
   (Please see provided data in PE Subcommittee folder)

   No it is billed with an E/M office visit 31% of the time.

4. What specialty is the dominant provider in the nonfacility? *Anesthesiology – 22%*
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? *57%*
   Is the dominant provider in the nonfacility different then for the global? *No.*
   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. *N/A*

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*

The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Table, exam – default
    Mayo stand - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

18. Please include an explanation of each line item:

Code	Supply	64421
SC057	syringe 5-6ml	For performing the procedure
SG051	gauze, non-sterile 4in x 4in	For performing the procedure

SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SC029	needle, 18-27g	For performing the procedure
SG021	bandage, strip 0.75in x 3in (Bandaid)	For performing the procedure

CPT Code:___64425_____
Specialty Society_____AAPM, AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves

Global Period:__0___ Meeting Date: __October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64425 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

   Is this code(s) typically billed with the E/M service in the nonfacility?
   (Please see provided data in PE Subcommittee folder)

   No it is billed with an E/M office visit 33% of the time.

4. What specialty is the dominant provider in the nonfacility? *Anesthesiology – 20%*
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? *61%*
   Is the dominant provider in the nonfacility different then for the global? *No.*
   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

   We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Table, exam – default
    Mayo stand - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).*

17. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

18. Please include an explanation of each line item:

Code	Supply	64425
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Skribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure; more injectate is required for this procedure since with this injection a "loss of resistance technique" is used
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure; more injectate is required for this procedure since with this injection a "loss of resistance technique" is used
SC038	needle, epidural (RK)	For performing the procedure; this needle has a blunted end, which is safer for the "loss of resistance technique" used in the injection to avoid injury with an injection that goes too deep
SC051	syringe 10-12ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

CPT Code:___64445_____
Specialty Society_____AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single

Global Period:__0___ Meeting Date: __October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64445 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

   Is this code(s) typically billed with the E/M service in the nonfacility?
   (Please see provided data in PE Subcommittee folder)

   No it is billed with an E/M office visit 29% of the time.

4. What specialty is the dominant provider in the nonfacility? *Internal Medicine – 28%*
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? *59%*
   Is the dominant provider in the nonfacility different then for the global? *For the global, the dominant specialty is Anesthesiology (37%)*

   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

   We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Table, exam – default
    Nerve stimulator (eg, for nerve block) – default
    ECG, 3-channel (with SpO2, NIBP, temp, respt) – default
    Mayo stand - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here:
Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).

18. Please include an explanation of each line item:

Code	Supply	64445
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Skribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SD050	electrode needle, injectable (Myoject)	For performing the procedure
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

CPT Code:___64447_____
Specialty Society_____ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, single

Global Period:__0___ Meeting Date: __October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64447 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

   Is this code(s) typically billed with the E/M service in the nonfacility?
   (Please see provided data in PE Subcommittee folder)

   No it is billed with an E/M office visit 1% of the time.

4. What specialty is the dominant provider in the nonfacility? *Internal Medicine – 61%*
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? *This service is provided in the non-facility setting 13% of the time.*

   Is the dominant provider in the nonfacility different then for the global? *For the global, the dominant specialty is Anesthesiology (77%)*

   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time. *N/A*

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

    Table, exam – default
    Nerve stimulator (eg, for nerve block) – default
    ECG, 3-channel (with SpO2, NIBP, temp, respt) – default
    Mayo stand - default

17. If there is any other item on your spreadsheet that needs further explanation please include here: *Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).*

18. Please include an explanation of each line item:

Code	Supply	64447
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Skribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC053	syringe 20ml	For performing the procedure
SC051	syringe 10-12ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

CPT Code:___64450_____
Specialty Society_____AAN, AAPM, AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch

Global Period:__0___ Meeting Date: __October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64450 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

   Is this code(s) typically billed with the E/M service in the nonfacility?
   (Please see provided data in PE Subcommittee folder)

   No it is billed with an E/M office visit 32% of the time.

4. What specialty is the dominant provider in the nonfacility? *Nurse Practitioners – 20%*
What percent of the time does the dominant provider provide the service(s) in the nonfacility? *63%*
Is the dominant provider in the nonfacility different then for the global? *For the global, the dominant specialty is Anesthesiology (26%)*

(Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

   We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are

not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code) *5 minutes*
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here: *We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: heart rate, blood pressure, body mass index, temperature, and oxidation level.*

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    Table, exam – default
    Mayo stand - default

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here:
Consent is obtained in the pre-service period of the service period on the day of the procedure (CA011), in addition to being obtained in the pre-service period (CA004).

18. Please include an explanation of each line item:

Code	Supply	64450
SA041	pack, basic injection	For performing the procedure
SA048	pack, minimum multi-specialty visit	For day of procedure
SK075	skin marking pen, sterile (Skin Skribe)	For performing the procedure
SH023	chlorhexidine 0.12% (Peridex)	For sterile prep
SH047	lidocaine 1%-2% inj (Xylocaine)	For performing the procedure
SH022	bupivacaine 0.5% inj (Marcaine)	For performing the procedure
SC051	syringe 10-12ml	For performing the procedure
SA088	tray, surgical skin prep, sterile	For sterile prep
SJ081	swab, patient prep, 1.5 ml (chloraprep)	For sterile prep

CPT Code:____64400_____
Specialty Society_____AAN, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)

Global Period:__0___ Meeting Date: _October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64400 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

   We are requesting an increase over the current total cost for clinical staff time. Based on our Expert Panel review we identified a number of areas where clinical staff time is involved when providing this service in a facility environment that are not currently included.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

CPT Code:____64400_____
Specialty Society_____AAN, ASA_____

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

CPT Code:____64415_____
Specialty Society_____ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single

Global Period:__0___ Meeting Date: _October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64415 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

   We are requesting an increase over the current total cost for clinical staff time. Based on our Expert Panel review we identified a number of areas where clinical staff time is involved when providing this service in a facility environment that are not currently included.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item: *N/A*

CPT Code:____64417_____
Specialty Society_____ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; axillary nerve

Global Period:__0___ Meeting Date: _October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64417 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

CPT Code:____64417_____
Specialty Society_____ASA_____

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item: *N/A*

CPT Code:____64420_____
Specialty Society_____AAPM, AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerve, single level

Global Period:__0___ Meeting Date: _October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64420 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item: *N/A*

CPT Code:____64421____
Specialty Society_____AAPM, AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each additional level (List separately in addition to code for primary procedure)

Global Period:__0___ Meeting Date: _October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64421 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item: *N/A*

CPT Code:____64425____
Specialty Society_____AAPM, AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves

Global Period:__0___ Meeting Date: _October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64425 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

CPT Code:____64425____
Specialty Society_____AAPM, AAPM&R, ASA_____

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item: *N/A*

CPT Code:____64445____
Specialty Society____AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single

Global Period:__0___ Meeting Date: _October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64445 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

   We are requesting an increase over the current total cost for clinical staff time. Based on our Expert Panel review we identified a number of areas where clinical staff time is involved when providing this service in a facility environment that are not currently included.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item: *N/A*

CPT Code:____64447____
Specialty Society____ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, single

Global Period:__0___ Meeting Date: _October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64447 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:

   We are requesting an increase over the current total cost for clinical staff time. Based on our Expert Panel review we identified a number of areas where clinical staff time is involved when providing this service in a facility environment that are not currently included.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item: *N/A*

CPT Code:____64449____
Specialty Society____ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)

Global Period:__0___ Meeting Date: _October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64449 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

   We are requesting an increase over the current total cost for clinical staff time. Based on our Expert Panel review we identified a number of areas where clinical staff time is involved when providing this service in a facility environment that are not currently included.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item: *N/A*

CPT Code:____64450____
Specialty Society____AAN, AAPM, AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch

Global Period:__0___ Meeting Date: _October 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   An Expert Panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations. The Expert Panel was composed of clinicians from across the US practicing in small and large private practices and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Using the current direct PE inputs of code 64450 as the reference code

3. Is this code(s) typically billed with an E/M service?

   No.

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: *N/A*

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item: *N/A*

CPT Code:___64408_____
Specialty Society_____AAOHNS_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

Global Period:__000___ Meeting Date: ___September 2018_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialties formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and multiple clinical experts who practice in the areas of oral and maxillofacial surgery and general otolaryngologists. The expert panel members also practice in settings that vary by size, geography, and represent both private and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   We utilized the existing PE inputs as a reference for CPT Code 64408.

3. Is this code(s) typically billed with an E/M service? **No**
   Is this code(s) typically billed with the E/M service in the nonfacility? **No**
   (Please see provided data in PE Subcommittee folder)

4. What specialty is the dominant provider in the nonfacility? **Otolaryngology**
   What percent of the time does the dominant provider provide the service(s) in the nonfacility? **91%**
   Is the dominant provider in the nonfacility different then for the global? **No**
   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

Pre time: we are requesting five minutes in the non-facility to schedule space for the procedure. This is a necessary activity for staff to complete in order to ensure a time block in the facility to conduct the procedure.

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

Pre time – see rationale above

Intra time – time requested is below existing

Post time – time requested is the same as existing

Supplies – we have removed the injection pack as it included materials not needed for the procedure. We replaced this with the individual items we do need such as the blunt tip needle to draw up the local anesthetic, an alcohol pad to clean the injection site, one spinal needle to inject, gauze to hold pressure after the injection, a Band-Aid for the injection site.

Equipment – is reduced from existing inputs

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

   Staff must take the following vitals: Heart rate, blood pressure and pulse oximetry

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff are present during the entire procedure, handing the physician the syringe, handing gauze and holding pressure to control bleeding and prevent a hematoma and passing the dressing supply.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. **N/A**

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

    Existing PE was all lumped into the assist during procedure line item. We have divided out clinical staff activities for the necessary activities and assigned the standard time for those activities per the PE guidelines. The intra time for this procedure is only 5 minutes, so the prior 28 minutes for intra assisting was clearly not accounting for only directly assisting during the procedure.

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. **N/A**

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

    The only equipment recommended is the exam chair EF008. The formula chosen is the "default" PE formula, as it is not highly technical equipment.

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**

17. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**

18. Please include an explanation of each line item:

Line 33 – greet patient, gown them and ensure any records needed are available.
Line 34 – obtain 3 vitals: Heart rate, blood pressure and pulse oximetry
Line 35 – provide education and consent to patient prior to procedure.
Line 37 – prepare the room for the patient's arrival and set up materials needed for procedure.
Line 49 – the staff are assisting directly during the entire 5 minute procedure handing the physician the syringe, handing gauze and holding pressure to control bleeding and prevent a hematoma and passing the dressing supply.
Line 60 – patients are monitored for 30 minutes after the procedure, so the standard time of 15 minutes per hour was reduced to accurately reflect 30 minutes of monitoring (7.5 rounded up).
Line 63 – staff clean the room and chair after the procedure.
Line 67 – check dressings, wounds – ensure there is no hematoma after procedure
Line 73 – review home care instructions – review potential signs to look for and what the patient will experience the days following procedure. Also when to remove bandaid and when they can shower, etc.
Line 84 – conducting phone calls a day or two after procedure to make sure the patient is doing well and no complications have arisen.
Line 103 – multi-specialty pack – used for prepping the room during procedure, gowning, and maintaining a safe environment (gloves).
Line 104 – spinal needle – used to inject the vagus nerve
Line 105 – needle, blunt tip – used to draw up the bupivacaine
Line 106 – syringe – used to draw up the bupivacaine
Line 107 – bupivacaine – local anesthetic to numb around the vagus nerve
Line 108 – alcohol swab – used to clean the injection site before and after the procedure.
Line 109 – Bandaid – used to cover the injection site after the procedure.
Line 110 – gauze non-sterile – used to apply pressure after the injection is complete.
Line 119 – exam chair – required for the procedure as the patient sits in it during the injection and the headrest is used for positioning the neck.

CPT Code:____64408_____
Specialty Society_____AAN, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

Global Period:__000___ Meeting Date: ____Sptebmer 2018____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Our specialties formed a panel of experts to develop practice expense recommendations for this family of codes. The panel was comprised of our RUC Advisors and multiple clinical experts who practice in the areas of oral and maxillofacial surgery and general otolaryngologists. The expert panel members also practice in settings that vary by size, geography, and represent both private and academic settings.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   We utilized the existing PE inputs as a reference for CPT Code 64408.

3. Is this code(s) typically billed with an E/M service? **No**

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: **N/A**

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: **N/A**

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: **N/A**

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

We are requesting the addition of 5 minutes of pre time for staff to schedule space in the facility for this procedure. We are also recommending removal of the 3 minutes for coordinating post procedure services and moving that time in the post period to conduct patient communications, as the staff call to check on the patient a few days after the procedure to ensure no complications have arisen.

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. **N/A**

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: **N/A**

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here: **N/A**

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: **N/A**

13. If there is any other item on your spreadsheet that needs further explanation please include here: **N/A**

14. Please include an explanation of each line item:

Line 17 – scheduling space in the facility requires staff time to ensure there is room to perform the procedure when performed in the facility setting.
Line 84 – conducting phone calls a day or two after procedure to make sure the patient is doing well and no complications have arisen.

CPT Code: 64430 (ACOG, ASA, AAPM)
64435 (ACOG)

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

Global Period: 000 **REVISED** **Meeting Date:** October 2018

CPT Long Descriptor(s):

64430 *Injection, anesthetic agent; pudendal nerve*

64435 *Injection, anesthetic agent; paracervical (uterine) nerve*

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1. **Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:**

   ACOG, ASA and AAPM convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for these injection procedures.

2. **You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:**

   CPT Codes 64430 and 64435 are existing CPT codes. As such, we included the current direct practice expense inputs on the PE spreadsheet.

3. **Is this code(s) typically billed with an E/M service?**
   Is this code(s) typically billed with the E/M service in the nonfacility?
   (Please see provided data in PE Subcommittee folder)

   These services are not typically reported with E/M:
   64430 – 23%
   64435 – 0%

   These services are not typically reported with E/M in the nonfacility:
   64430 – 43%
   64435 – 0%

4. **What specialty is the dominant provider in the nonfacility?**
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different then for the global?
   (Please see provided data in PE Subcommittee folder)

   OB/GYN is the dominant provider in the nonfacility:
   64430 – 28%
   64435 – 46%

OB/GYN is also the dominant provider for the globals in the nonfacility:
64430 – 39%
64435 – 67%

5. **If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:**

   N/A

6. **If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.**

   N/A

7. **If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:**

   N/A

8. **How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)**
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

   Prior to CMS increasing the vital signs to 5 minutes there were 3 minutes for obtain vital signs. We are recommending 5 minutes for obtain vital signs, based on the vital signs standards (4-6). The vital signs for these procedures include: height, weight, blood pressure and heart rate.

9. **Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:***

   Nurse supplies physician with needed supplies and instruments. Assists with fluid management. Chaperone.
   Note: Patient is in dorsal lithotomy position throughout the procedure.

10. **If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.**

    N/A

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:

N/A

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:

We are recommending a new supply item, "Paracerv/Pudendal Block Tray, Sterile (Medline Item #BXT4540AH)" which is specifically designed for vaginal injection procedures. The needle guide is utilized to safely locate insertion of the needle for anesthetic delivery. It appears the existing CMS inputs do not describe this safety guide technology.

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:

N/A

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

EF023 table, exam – Default
EQ168 light, exam – Default
EF027 table, instrument, mobile - Default
**Note: Because we are using the default equipment formula, CA022 time is not included in the equipment formulas. However, the patient does recover in the room, so that time is not being captured.*

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

The patient recovers for approximately 15 minutes after the procedure, with the nurse coming to check in on the patient. We are requesting 3 minutes for post procedure monitoring (instead of 3.75 minutes). **See note in #15.*

Post procedure phone call is to check on the effects of the medication, muscle weakness, etc.

17. If there is any other item on your spreadsheet that needs further explanation please include here:

N/A

18. Please include an explanation of each line item:

SA048	pack, minimum multi-specialty visit	Patient gown, exam table paper, pillow case
SA051	pack, pelvic exam	SJ032 lubricating jelly SK052 pad, mini SD118 specula, vaginal SJ052 swab, procto
SB006	drape, non-sterile, sheet 40in x 60in	Patient drape
SH021	bupivacaine 0.25% inj (Marcaine)	Anesthetic injected
SJ052	Swab, procto	Hemostasis and fluid management (2 additional from the SA051)
SJ043	Povidone swabsticks	Sterilization of the operative site
NEW	Paracerv/Pudendal Block Tray, Sterile	Kit includes: 20g 6" needle w/ 1/4" spacer, 10cc control syringe, 22g 1 1/2" needle, needle guide, gauze sponge and underpad

CPT Code: 64430 (ACOG, ASA and AAPM)
64435 (ACOG)

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

Global Period: 000 **Meeting Date:** October 2018

CPT Long Descriptor(s):

64430 *Injection, anesthetic agent; pudendal nerve*

64435 *Injection, anesthetic agent; paracervical (uterine) nerve*

---

1. **Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:**

   ACOG, ASA and AAPM convened a panel that included a number of experts familiar with these services to evaluate the direct practice expense inputs for these injection procedures.

2. **You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:**

   CPT Codes 64430 and 64435 are existing CPT codes. As such, we included the current direct practice expense inputs on the PE spreadsheet.

3. **Is this code(s) typically billed with an E/M service?**

   These services are not typically reported with E/M:
   64430 – 23%
   64435 – 0%

4. **If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:**

   We are recommending 8 minutes of pre service time for these 000 day services.
   - CA001 Complete pre-service diagnostic and referral forms – 3 min
     Anesthesia requires CBC, pregnancy test
   - CA004 Provide pre-service education/obtain consent – 5 min
     Consent is completed in the office and sent to the hospital

5. **If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence:**

   N/A

6. **If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here:**

   N/A

7. **If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:**

   N/A

8. **If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.**

   N/A

9. **If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:**

   N/A

10. **If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:**

    N/A

11. **List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:**

    N/A

12. **If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:**

    N/A

13. If there is any other item on your spreadsheet that needs further explanation please include here:

N/A

14. **Please include an explanation of each line item:**

N/A

	A	B	D	E	F	I	J	K	L	M	N	O	P
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2	**REVISED**	***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.*** ***Please do not modify formulas in gray shaded cells*** ***Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**64400**		**64400**		**64408**		**64408**	
3		***RUC Collaboration Website***				Injection, anesthetic agent; trigeminal nerve, any division or branch		Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary,		Injection, anesthetic agent; vagus nerve		Injection, anesthetic agent; vagus nerve	
4	**Clinical Activity Code**	**Meeting Date: October 2018** **Tab: 9 Somatic Nerve Injection** **Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**0**	**0**			**0**	**0**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 41.92**	**$ 6.29**	**$ 33.32**	**$ 4.44**	**$ 35.54**	**$ 10.36**	**$ 20.32**	**$ 2.96**
8		**TOTAL CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**65.0**	**17.0**	**33.0**	**12.0**	**47.0**	**28.0**	**33.0**	**8.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**8.0**	**14.0**	**3.0**	**9.0**	**16.0**	**25.0**	**0.0**	**5.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**54.0**	**0.0**	**27.0**	**0.0**	**28.0**	**0.0**	**30.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	0.37	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE**				**$ 24.05**	**$ 6.29**	**$ 12.21**	**$ 4.44**	**$ 17.39**	**$ 10.36**	**$ 12.21**	**$ 2.96**
13		**PRE-SERVICE PERIOD**											
14		**Start: Following visit when decision for surgery or procedure made**											
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37		3		**0**				
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37				**3**				
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37		3		3				5
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37	5	5	**0**	**0**				
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	3	3	3	3				
20	CA006	Confirm availability of prior images/studies	L051B	RN/Diagnostic	0.51								
21	CA007	Review patient clinical extant information and	L037D	RN/LPN/MTA	0.37								
22	CA008	Perform regulatory mandated quality assurance	L037D	RN/LPN/MTA	0.37					16	25		
29		**End: When patient enters office/facility for surgery/procedure**											
30		**SERVICE PERIOD**											
31		**Start: When patient enters office/facility for surgery/procedure:**											
32		**Pre-Service (of service period)**											
33	CA009	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	0.37	3		3				3	
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37	5		5				3	
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37			3				3	
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37								
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37	5		2				2	
38	CA013	Prepare room, equipment and supplies	L051B	RN/Diagnostic	0.51								
39	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37								
40	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37								
41	CA016	Prepare, set-up and start IV, initial positioning and	L037D	RN/LPN/MTA	0.37	2		2					
42	CA016	Prepare, set-up and start IV, initial positioning and	L051B	RN/Diagnostic	0.51								
43	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37								
50		**Intra-service (of service period)**											
51	CA018	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA	0.37	0		6				5	
52	CA019	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA	0.37	18							
53	CA020	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA	0.37								
54	CA021	Perform procedure/service---NOT directly related to	L037D	RN/LPN/MTA	0.37					28	0		
61	CA021	Perform procedure/service---NOT directly related to	L051B	RN/Diagnostic	0.51								
62		**Post-Service (of service period)**											
63	CA022	Monitor patient following procedure/service,	L037D	RN/LPN/MTA	0.37	15		**0**				8	
64	CA023	Monitor patient following procedure/service, no	L037D	RN/LPN/MTA	0.37								
65	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37	3		3				3	
66	CA024	Clean room/equipment by clinical staff	L051B	RN/Diagnostic	0.51								
67	CA025	Clean scope	L037D	RN/LPN/MTA	0.37								
68	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37								
69	CA027	Complete post-procedure diagnostic forms, lab and x-	L037D	RN/LPN/MTA	0.37								
70	CA028	Review/read post-procedure x-ray, lab and pathology	L037D	RN/LPN/MTA	0.37								
71	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37	1		1				1	
72	CA030	Technologist QC's images in PACS, checking for all	L037D	RN/LPN/MTA	0.37								
73	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37								
74	CA031	Review examination with interpreting MD/DO	L051B	RN/Diagnostic	0.51								
75	CA032	Scan exam documents into PACS. Complete exam in	L037D	RN/LPN/MTA	0.37								
76	CA032	Scan exam documents into PACS. Complete exam in	L051B	RN/Diagnostic	0.51								
77	CA033	Perform regulatory mandated quality assurance	L037D	RN/LPN/MTA	0.37								
78	CA034	Document procedure (nonPACS) (e.g. mandated	L037D	RN/LPN/MTA	0.37								
79	CA035	Review home care instructions, coordinate	L037D	RN/LPN/MTA	0.37	2		2				2	
80	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**		**n/a**	
87		**End: Patient leaves office**											
88		**POST-SERVICE PERIOD**											
89		**Start: Patient leaves office/facility**											
90	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37	3	3	3	3			3	3
91	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37					3	3		
92		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
93		99211 16 minutes	16										
94		99212 27 minutes	27										
95		99213 36 minutes	36										
96		99214 53 minutes	53										
97		99215 63 minutes	63										
98	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
105		**End: with last office visit before end of global period**											

	A	B	D	E	F	I	J	K	L	M	N	O	P
1	RUC Practice Expense Spreadsheet					CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2	REVISED	*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.				64400		64400		64408		64408	
3		RUC Collaboration Website				Injection, anesthetic agent; trigeminal nerve, any division or branch		Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary,		Injection, anesthetic agent; vagus nerve		Injection, anesthetic agent; vagus nerve	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per								
5		LOCATION				Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD				0	0			0	0		
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME				$ 41.92	$ 6.29	$ 33.32	$ 4.44	$ 35.54	$ 10.36	$ 20.32	$ 2.96
8		TOTAL CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	65.0	17.0	33.0	12.0	47.0	28.0	33.0	8.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	8.0	14.0	3.0	9.0	16.0	25.0	0.0	5.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	54.0	0.0	27.0	0.0	28.0	0.0	30.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D	RN/LPN/MTA	0.37	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
106	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT									
107		TOTAL COST OF SUPPLY QUANTITY x PRICE				$ 17.55	$ -	$ 21.01	$ -	$ 17.55	$ -	$ 7.87	$ -
108	SA041	pack, basic injection	11.67	pack		1		1		1			
109	SA048	pack, minimum multi-specialty visit	1.143	pack		1		1		1		1	
110	SA051	pack, pelvic exam	1.172	pack									
111	SC040	needle, Kopan	18.75	item									
112	SK075	skin marking pen, sterile (Skin Skribe)	1.048	item				1					
113	SH023	chlorhexidine 0.12% (Peridex)	0.408	oz				1					
114	SC028	needle, 18-26g 1.5-3.5in, spinal	3.314	item		1		1		1		1	
115	SC034	needle, blunt tip	0.33	item						new		1	
116	SC057	syringe 5-6ml	0.15	item		1				1		1	
117	SH021	bupivacaine 0.25% inj (Marcaine)	0.254	ml		5		5		5		5	
118	SB006	drape, non-sterile, sheet 40in x 60in	0.222	item									
119	SJ052	swab, procto 16in	0.117	item									
120	SJ043	povidone swabsticks (3 pack uou)	0.409	item									
121	1	Invoice #1850307197	5.24	item									
122	SJ053	swab-pad, alcohol	0.013	item						new		2	
123	SG021	bandage, strip 0.75in x 3in (Bandaid)	0.043	item						new		1	
124	SG056	gauze, sterile 4in x 4in (10 pack uou)	0.798	item				2		new		2	
125	SH047	lidocaine 1%-2% inj (Xylocaine)	0.035	ml									
126	SD050	electrode needle, injectable (Myoject)	20	item									
127	SH022	bupivacaine 0.5% inj (Marcaine)	0.1	ml									
128	SC038	needle, epidural (RK)	10	item									
129	SC053	syringe 20ml	0.558	item				1					
130	SC051	syringe 10-12ml	0.184	item									
131	SA088	tray, surgical skin prep, sterile	6.7647	tray				0					
132	SD269	Grounding pad	2.76	item									
133	SB019	drape-towel, sterile 18in x 26in	0.282	item									
134	SC029	needle, 18-27g	0.089	item									
135	SG021	bandage, strip 0.75in x 3in (Bandaid)	0.043	item									
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)	1.04	item				0					
137	SB005	cover-condom, transducer or ultrasound probe	0.35	item									
138	SJ033	lubricating jelly (Surgilube)	0.501	oz									
139	SM012	disinfectant spray (Transeptic)	0.028	ml									
140	SM021	sanitizing cloth-wipe (patient)	0.037	item									
141		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*											
143	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute								
144		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE				$ 0.32	$ -	$ 0.10	$ -	$ 0.60	$ -	$ 0.24	$ -
145	EF023	table, exam	1338.17	Default	0.003	107		25		88			
146	EQ168	light, exam	1630.12	Default	0.0043								
147	EF027	table, instrument, mobile	634	Default	0.0014								
148	EQ211	pulse oximeter w-printer	1207.18	Default	0.0039					88			
149	EF008	chair with headrest, exam, reclining	4836.33	Default	0.0108					new		20	
150	EQ184	nerve stimulator (eg, for nerve block)	572.3	Default	0.0018								
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	4322.5	Default	0.014			0					
152	EF018	stretcher	1915	Default	0.0051								
153	EF015	mayo stand	530.76		0.0012			25				20	
154	ED050	Technologist PACS workstation	5557		0.022								
155	ED053	Professional PACS Workstation	14616.93		0.0579								
156	EQ250	ultrasound unit, portable	29999		0.1162								
157													
158		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*											

	A	B	Q	R	S	T	U	V	W	X	Y	Z	AA
1	RUC Practice Expense Spreadsheet		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMM
2	REVISED	*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.	64415		64415		64417		64417		64420		64
3		RUC Collaboration Website	Injection, anesthetic agent; brachial plexus, single		Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single		Injection, anesthetic agent; axillary nerve		Injection(s), anesthetic agent(s) and/or steroid; axillary nerve		Injection, anesthetic agent; intercostal nerve, single		Injecti anesthetic and/or intercost single
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,											
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD	0	0			0	0			0	0	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 49.78	$ -	$ 49.95	$ 4.44	$ 60.79	$ 6.29	$ 69.95	$ 4.44	$ 40.05	$ 6.29	$ 35.67
8		TOTAL CLINICAL STAFF TIME	39.0	0.0	47.0	12.0	58.0	17.0	45.0	12.0	60.0	17.0	52.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	3.0	9.0	8.0	14.0	3.0	9.0	8.0	14.0	3.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	36.0	0.0	41.0	0.0	47.0	0.0	39.0	0.0	49.0	0.0	46.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	0.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE	$ 14.43	$ -	$ 17.39	$ 4.44	$ 21.46	$ 6.29	$ 16.65	$ 4.44	$ 22.20	$ 6.29	$ 19.24
13		PRE-SERVICE PERIOD											
14		Start: Following visit when decision for surgery or pr											
15	CA001	Complete pre-service diagnostic and referral forms				0		3		0		3	
16	CA002	Coordinate pre-surgery services (including test results)				3				3			
17	CA003	Schedule space and equipment in facility				3		3		3		3	
18	CA004	Provide pre-service education/obtain consent			0	0	5	5	0	0	5	5	0
19	CA005	Complete pre-procedure phone calls and prescription			3	3	3	3	3	3	3	3	3
20	CA006	Confirm availability of prior images/studies											
21	CA007	Review patient clinical extant information and											
22	CA008	Perform regulatory mandated quality assurance											
29		End: When patient enters office/facility for surgery/pr											
30		SERVICE PERIOD											
31		Start: When patient enters office/facility for surgery/p											
32		Pre-Service (of service period)											
33	CA009	Greet patient, provide gowning, ensure appropriate	3		3		3		3		3		3
34	CA010	Obtain vital signs	5		5		5		5		5		5
35	CA011	Provide education/obtain consent			3				3				3
36	CA012	Review requisition, assess for special needs											
37	CA013	Prepare room, equipment and supplies	2		0		5		0		5		2
38	CA013	Prepare room, equipment and supplies											
39	CA014	Confirm order, protocol exam											
40	CA015	Setup scope (nonfacility setting only)											
41	CA016	Prepare, set-up and start IV, initial positioning and	2		0		2		0		2		2
42	CA016	Prepare, set-up and start IV, initial positioning and											
43	CA017	Sedate/apply anesthesia											
50		Intra-service (of service period)											
51	CA018	Assist physician or other qualified healthcare	0		12		12		10				10
52	CA019	Assist physician or other qualified healthcare	10								11		
53	CA020	Assist physician or other qualified healthcare											
54	CA021	Perform procedure/service---NOT directly related to											
61	CA021	Perform procedure/service---NOT directly related to											
62		Post-Service (of service period)											
63	CA022	Monitor patient following procedure/service,	0		15		15		15		15		15
64	CA023	Monitor patient following procedure/service, no	8										
65	CA024	Clean room/equipment by clinical staff	3		0		3		0		3		3
66	CA024	Clean room/equipment by clinical staff											
67	CA025	Clean scope											
68	CA026	Clean surgical instrument package											
69	CA027	Complete post-procedure diagnostic forms, lab and x-											
70	CA028	Review/read post-procedure x-ray, lab and pathology									2		
71	CA029	Check dressings, catheters, wounds	1		1		1		1		1		1
72	CA030	Technologist QC's images in PACS, checking for all											
73	CA031	Review examination with interpreting MD/DO											
74	CA031	Review examination with interpreting MD/DO											
75	CA032	Scan exam documents into PACS. Complete exam in											
76	CA032	Scan exam documents into PACS. Complete exam in											
77	CA033	Perform regulatory mandated quality assurance											
78	CA034	Document procedure (nonPACS) (e.g. mandated											
79	CA035	Review home care instructions, coordinate	2		2		1		2		2		2
80	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a		n/a
87		End: Patient leaves office											
88		POST-SERVICE PERIOD											
89		Start: Patient leaves office/facility											
90	CA037	Conduct patient communications	3		3	3	3	3	3	3	3	3	3
91	CA038	Coordinate post-procedure services											
92		*Office visits: List Number and Level of Office Visits*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
93		99211 16 minutes											
94		99212 27 minutes											
95		99213 36 minutes											
96		99214 53 minutes											
97		99215 63 minutes											
98	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
105		End: with last office visit before end of global period											

	A	B	Q	R	S	T	U	V	W	X	Y	Z	AA
1	RUC Practice Expense Spreadsheet		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMM
2	REVISED	*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.	64415		64415		64417		64417		64420		64
3		RUC Collaboration Website	Injection, anesthetic agent; brachial plexus, single		Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, single		Injection, anesthetic agent; axillary nerve		Injection(s), anesthetic agent(s) and/or steroid; axillary nerve		Injection, anesthetic agent; intercostal nerve, single		Injecti anesthetic and/or intercost single
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,											
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD	0	0			0	0			0	0	
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 49.78	$ -	$ 49.95	$ 4.44	$ 60.79	$ 6.29	$ 69.95	$ 4.44	$ 40.05	$ 6.29	$ 35.67
8		TOTAL CLINICAL STAFF TIME	39.0	0.0	47.0	12.0	58.0	17.0	45.0	12.0	60.0	17.0	52.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	3.0	9.0	8.0	14.0	3.0	9.0	8.0	14.0	3.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	36.0	0.0	41.0	0.0	47.0	0.0	39.0	0.0	49.0	0.0	46.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	0.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
106	Supply Code	MEDICAL SUPPLIES											
107		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ 34.67	$ -	$ 31.28	$ -	$ 39.01	$ -	$ 52.06	$ -	$ 17.55	$ -	$ 15.06
108	SA041	pack, basic injection	1		1		1	0	1		1		1
109	SA048	pack, minimum multi-specialty visit			1		1	0	1		1		1
110	SA051	pack, pelvic exam											
111	SC040	needle, Kopan											
112	SK075	skin marking pen, sterile (Skin Skribe)			1				1				1
113	SH023	chlorhexidine 0.12% (Peridex)			1				1				
114	SC028	needle, 18-26g 1.5-3.5in, spinal									1		
115	SC034	needle, blunt tip											1
116	SC057	syringe 5-6ml									1		
117	SH021	bupivacaine 0.25% inj (Marcaine)					20	0	20		5		
118	SB006	drape, non-sterile, sheet 40in x 60in											
119	SJ052	swab, procto 16in											
120	SJ043	povidone swabsticks (3 pack uou)											
121	1	Invoice #1850307197											
122	SJ053	swab-pad, alcohol											1
123	SG021	bandage, strip 0.75in x 3in (Bandaid)											
124	SG056	gauze, sterile 4in x 4in (10 pack uou)			2				2				
125	SH047	lidocaine 1%-2% inj (Xylocaine)			5								5
126	SD050	electrode needle, injectable (Myoject)	1				1		1				
127	SH022	bupivacaine 0.5% inj (Marcaine)	30		30								5
128	SC038	needle, epidural (RK)			1				1				
129	SC053	syringe 20ml			2		2		2				
130	SC051	syringe 10-12ml											1
131	SA088	tray, surgical skin prep, sterile			0				0				
132	SD269	Grounding pad			0								
133	SB019	drape-towel, sterile 18in x 26in			4								
134	SC029	needle, 18-27g											
135	SG021	bandage, strip 0.75in x 3in (Bandaid)											
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)			0				0				
137	SB005	cover-condom, transducer or ultrasound probe											
138	SJ033	lubricating jelly (Surgilube)											
139	SM012	disinfectant spray (Transeptic)											
140	SM021	sanitizing cloth-wipe (patient)											
141		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*											
143	Equipment Code	EQUIPMENT											
144		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ 0.68	$ -	$ 1.27	$ -	$ 0.32	$ -	$ 1.24	$ -	$ 0.30	$ -	$ 1.36
145	EF023	table, exam	36		24		89		22				29
146	EQ168	light, exam											
147	EF027	table, instrument, mobile											
148	EQ211	pulse oximeter w-printer											
149	EF008	chair with headrest, exam, reclining											
150	EQ184	nerve stimulator (eg, for nerve block)	36		0		29		0				
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	36		84				82				89
152	EF018	stretcher									60		
153	EF015	mayo stand			24				22				29
154	ED050	Technologist PACS workstation											
155	ED053	Professional PACS Workstation											
156	EQ250	ultrasound unit, portable											
157													
158		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*											

	A	B	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL
1	RUC Practice Expense Spreadsheet		MENDED	CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT	
2	REVISED	*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.	420	64421		64421		64425		64425		64430	
3		RUC Collaboration Website	on(s), c agent(s) steroid; al nerve, level	Injection, anesthetic agent; intercostal nerves, multiple, regional block		Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each		Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves		Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves		Injection, anesthetic agent; pudendal nerve	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,											
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD		ZZZ	ZZZ			0	0			0	0
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 4.44	$ 51.53	$ 6.29	$ 6.48	$ -	$ 37.78	$ 6.29	$ 48.54	$ 4.44	$ 54.02	$ 6.29
8		TOTAL CLINICAL STAFF TIME	12.0	72.0	17.0	10.0	0.0	54.0	17.0	53.0	12.0	53.0	17.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	9.0	8.0	14.0	0.0	0.0	8.0	14.0	3.0	9.0	8.0	14.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	61.0	0.0	10.0	0.0	43.0	0.0	47.0	0.0	42.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	0.0	0.0	3.0	3.0	3.0	3.0	3.0	3.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE	$ 4.44	$ 26.64	$ 6.29	$ 3.70	$ -	$ 19.98	$ 6.29	$ 19.61	$ 4.44	$ 19.61	$ 6.29
13		PRE-SERVICE PERIOD											
14		Start: Following visit when decision for surgery or pr											
15	CA001	Complete pre-service diagnostic and referral forms	0		3				3		0		3
16	CA002	Coordinate pre-surgery services (including test results)	3								3		
17	CA003	Schedule space and equipment in facility	3		3				3		3		3
18	CA004	Provide pre-service education/obtain consent	0	5	5			5	5	0	0	5	5
19	CA005	Complete pre-procedure phone calls and prescription	3	3	3			3	3	3	3	3	3
20	CA006	Confirm availability of prior images/studies											
21	CA007	Review patient clinical extant information and											
22	CA008	Perform regulatory mandated quality assurance											
29		End: When patient enters office/facility for surgery/pr											
30		SERVICE PERIOD											
31		Start: When patient enters office/facility for surgery/p											
32		Pre-Service (of service period)											
33	CA009	Greet patient, provide gowning, ensure appropriate		3				3		3		3	
34	CA010	Obtain vital signs		5				5		5		3	
35	CA011	Provide education/obtain consent								3			
36	CA012	Review requisition, assess for special needs											
37	CA013	Prepare room, equipment and supplies		5				3		2		5	
38	CA013	Prepare room, equipment and supplies											
39	CA014	Confirm order, protocol exam											
40	CA015	Setup scope (nonfacility setting only)											
41	CA016	Prepare, set-up and start IV, initial positioning and		2				2		2		2	
42	CA016	Prepare, set-up and start IV, initial positioning and											
43	CA017	Sedate/apply anesthesia											
50		Intra-service (of service period)											
51	CA018	Assist physician or other qualified healthcare		0		10		0		11			
52	CA019	Assist physician or other qualified healthcare		23				9					
53	CA020	Assist physician or other qualified healthcare										9	
54	CA021	Perform procedure/service---NOT directly related to											
61	CA021	Perform procedure/service---NOT directly related to											
62		Post-Service (of service period)											
63	CA022	Monitor patient following procedure/service,		15				15		15		15	
64	CA023	Monitor patient following procedure/service, no											
65	CA024	Clean room/equipment by clinical staff		3				3		3		3	
66	CA024	Clean room/equipment by clinical staff											
67	CA025	Clean scope											
68	CA026	Clean surgical instrument package											
69	CA027	Complete post-procedure diagnostic forms, lab and x-											
70	CA028	Review/read post-procedure x-ray, lab and pathology		2									
71	CA029	Check dressings, catheters, wounds		1				1		1		2	
72	CA030	Technologist QC's images in PACS, checking for all											
73	CA031	Review examination with interpreting MD/DO											
74	CA031	Review examination with interpreting MD/DO											
75	CA032	Scan exam documents into PACS. Complete exam in											
76	CA032	Scan exam documents into PACS. Complete exam in											
77	CA033	Perform regulatory mandated quality assurance											
78	CA034	Document procedure (nonPACS) (e.g. mandated											
79	CA035	Review home care instructions, coordinate		2				2		2			
80	CA036	Discharge day management		n/a		n/a		n/a		n/a		n/a	
87		End: Patient leaves office											
88		POST-SERVICE PERIOD											
89		Start: Patient leaves office/facility											
90	CA037	Conduct patient communications	3	3	3			3	3	3	3	3	3
91	CA038	Coordinate post-procedure services											
92		*Office visits: List Number and Level of Office Visits*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
93		99211 16 minutes											
94		99212 27 minutes											
95		99213 36 minutes											
96		99214 53 minutes											
97		99215 63 minutes											
98	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
105		End: with last office visit before end of global period											

	A	B	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL
1	RUC Practice Expense Spreadsheet		MENDED	CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT	
2	REVISED	*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.	420	64421		64421		64425		64425		64430	
3		RUC Collaboration Website	on(s), c agent(s) steroid; al nerve, level	Injection, anesthetic agent; intercostal nerves, multiple, regional block		Injection(s), anesthetic agent(s) and/or steroid; intercostal nerves, multiple, regional block, each		Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves		Injection(s), anesthetic agent(s) and/or steroid; ilioinguinal, iliohypogastric nerves		Injection, anesthetic agent; pudendal nerve	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,											
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD		ZZZ	ZZZ			0	0			0	0
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 4.44	$ 51.53	$ 6.29	$ 6.48	$ -	$ 37.78	$ 6.29	$ 48.54	$ 4.44	$ 54.02	$ 6.29
8		TOTAL CLINICAL STAFF TIME	12.0	72.0	17.0	10.0	0.0	54.0	17.0	53.0	12.0	53.0	17.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	9.0	8.0	14.0	0.0	0.0	8.0	14.0	3.0	9.0	8.0	14.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	61.0	0.0	10.0	0.0	43.0	0.0	47.0	0.0	42.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	0.0	0.0	3.0	3.0	3.0	3.0	3.0	3.0
106	Supply Code	MEDICAL SUPPLIES											
107		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ 24.58	$ -	$ 1.76	$ -	$ 17.55	$ -	$ 27.55	$ -	$ 34.16	$ -
108	SA041	pack, basic injection		1				1		1		1	
109	SA048	pack, minimum multi-specialty visit		1				1		1		1	
110	SA051	pack, pelvic exam										1	
111	SC040	needle, Kopan										1	
112	SK075	skin marking pen, sterile (Skin Skribe)								1			
113	SH023	chlorhexidine 0.12% (Peridex)								1			
114	SC028	needle, 18-26g 1.5-3.5in, spinal		3				1					
115	SC034	needle, blunt tip											
116	SC057	syringe 5-6ml						1		1		1	
117	SH021	bupivacaine 0.25% inj (Marcaine)		5				5				5	
118	SB006	drape, non-sterile, sheet 40in x 60in											
119	SJ052	swab, procto 16in											
120	SJ043	povidone swabsticks (3 pack uou)											
121	1	Invoice #1850307197											
122	SJ053	swab-pad, alcohol											
123	SG021	bandage, strip 0.75in x 3in (Bandaid)											
124	SG056	gauze, sterile 4in x 4in (10 pack uou)				1				2			
125	SH047	lidocaine 1%-2% inj (Xylocaine)				2				10			
126	SD050	electrode needle, injectable (Myoject)											
127	SH022	bupivacaine 0.5% inj (Marcaine)				2				10			
128	SC038	needle, epidural (RK)								1			
129	SC053	syringe 20ml		1		1							
130	SC051	syringe 10-12ml								1			
131	SA088	tray, surgical skin prep, sterile								0			
132	SD269	Grounding pad											
133	SB019	drape-towel, sterile 18in x 26in											
134	SC029	needle, 18-27g				1							
135	SG021	bandage, strip 0.75in x 3in (Bandaid)				1							
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)								0			
137	SB005	cover-condom, transducer or ultrasound probe											
138	SJ033	lubricating jelly (Surgilube)											
139	SM012	disinfectant spray (Transeptic)											
140	SM021	sanitizing cloth-wipe (patient)											
141		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*											
143	Equipment Code	EQUIPMENT											
144		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ 0.30	$ -	$ 1.02	$ -	$ 0.25	$ -	$ 1.38	$ -	$ 0.26	$ -
145	EF023	table, exam				10		85		30		87	
146	EQ168	light, exam											
147	EF027	table, instrument, mobile											
148	EQ211	pulse oximeter w-printer											
149	EF008	chair with headrest, exam, reclining											
150	EQ184	nerve stimulator (eg, for nerve block)											
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)				70				90			
152	EF018	stretcher		60	0								
153	EF015	mayo stand				10				30			
154	ED050	Technologist PACS workstation											
155	ED053	Professional PACS Workstation											
156	EQ250	ultrasound unit, portable											
157													
158		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*											

	A	B	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW
1	RUC Practice Expense Spreadsheet		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED		CURI
2	REVISED	*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.	64430		64435		64435		64445		64445		64
3		RUC Collaboration Website	Injection, anesthetic agent(s) and/or steroid; pudendal nerve		Injection, anesthetic agent; paracervical (uterine) nerve		Injection, anesthetic agent(s) and/or steroid; paracervical (uterine) nerve		Injection, anesthetic agent; sciatic nerve, single		Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single		Injection, agent; fem sin
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,											
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac
6		GLOBAL PERIOD			0	0			0	0			0
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ 23.78	$ 4.07	$ 54.02	$ 6.29	$ 21.89	$ 4.07	$ 50.94	$ -	$ 59.66	$ 4.44	$ 50.55
8		TOTAL CLINICAL STAFF TIME	34.0	11.0	53.0	17.0	29.0	11.0	42.0	0.0	52.0	12.0	41.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	8.0	8.0	14.0	0.0	8.0	0.0	0.0	3.0	9.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	31.0	0.0	42.0	0.0	26.0	0.0	39.0	0.0	46.0	0.0	38.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	3.0	3.0	3.0	3.0	0.0	3.0	3.0	3.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE	$ 12.58	$ 4.07	$ 19.61	$ 6.29	$ 10.73	$ 4.07	$ 15.54	$ -	$ 19.24	$ 4.44	$ 15.17
13		PRE-SERVICE PERIOD											
14		Start: Following visit when decision for surgery or pr											
15	CA001	Complete pre-service diagnostic and referral forms		3		3		3				0	
16	CA002	Coordinate pre-surgery services (including test results)										3	
17	CA003	Schedule space and equipment in facility				3						3	
18	CA004	Provide pre-service education/obtain consent		5	5	5		5			0	0	
19	CA005	Complete pre-procedure phone calls and prescription			3	3					3	3	
20	CA006	Confirm availability of prior images/studies											
21	CA007	Review patient clinical extant information and											
22	CA008	Perform regulatory mandated quality assurance											
29		End: When patient enters office/facility for surgery/pr											
30		SERVICE PERIOD											
31		Start: When patient enters office/facility for surgery/p											
32		Pre-Service (of service period)											
33	CA009	Greet patient, provide gowning, ensure appropriate	3		3		3		3		3		3
34	CA010	Obtain vital signs	5		3		5		5		5		5
35	CA011	Provide education/obtain consent	3				3				3		
36	CA012	Review requisition, assess for special needs											
37	CA013	Prepare room, equipment and supplies	2		5		2		2		2		2
38	CA013	Prepare room, equipment and supplies											
39	CA014	Confirm order, protocol exam											
40	CA015	Setup scope (nonfacility setting only)											
41	CA016	Prepare, set-up and start IV, initial positioning and	2		2		2		2		2		2
42	CA016	Prepare, set-up and start IV, initial positioning and											
43	CA017	Sedate/apply anesthesia											
50		Intra-service (of service period)											
51	CA018	Assist physician or other qualified healthcare	10				5		0		10		0
52	CA019	Assist physician or other qualified healthcare							11				10
53	CA020	Assist physician or other qualified healthcare			9								
54	CA021	Perform procedure/service---NOT directly related to											
61	CA021	Perform procedure/service---NOT directly related to											
62		Post-Service (of service period)											
63	CA022	Monitor patient following procedure/service,	3		15		3		10		15		10
64	CA023	Monitor patient following procedure/service, no											
65	CA024	Clean room/equipment by clinical staff	3		3		3		3		3		3
66	CA024	Clean room/equipment by clinical staff											
67	CA025	Clean scope											
68	CA026	Clean surgical instrument package											
69	CA027	Complete post-procedure diagnostic forms, lab and x-											
70	CA028	Review/read post-procedure x-ray, lab and pathology											
71	CA029	Check dressings, catheters, wounds			2				1		1		1
72	CA030	Technologist QC's images in PACS, checking for all											
73	CA031	Review examination with interpreting MD/DO											
74	CA031	Review examination with interpreting MD/DO											
75	CA032	Scan exam documents into PACS. Complete exam in											
76	CA032	Scan exam documents into PACS. Complete exam in											
77	CA033	Perform regulatory mandated quality assurance											
78	CA034	Document procedure (nonPACS) (e.g. mandated											
79	CA035	Review home care instructions, coordinate							2		2		2
80	CA036	Discharge day management	n/a		n/a		n/a		n/a		n/a		n/a
87		End: Patient leaves office											
88		POST-SERVICE PERIOD											
89		Start: Patient leaves office/facility											
90	CA037	Conduct patient communications	3	3	3	3	3	3	3		3	3	3
91	CA038	Coordinate post-procedure services											
92		*Office visits: List Number and Level of Office Visits*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
93		99211 16 minutes											
94		99212 27 minutes											
95		99213 36 minutes											
96		99214 53 minutes											
97		99215 63 minutes											
98	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
105		End: with last office visit before end of global period											

	A	B	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURR**
2	**REVISED**	***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**64430**		**64435**		**64435**		**64445**		**64445**		**64**
3		***RUC Collaboration Website***	Injection, anesthetic agent(s) and/or steroid; pudendal nerve		Injection, anesthetic agent; paracervical (uterine) nerve		Injection, anesthetic agent(s) and/or steroid; paracervical (uterine) nerve		Injection, anesthetic agent; sciatic nerve, single		Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, single		Injection, agent; fem sin
4	**Clinical Activity Code**	**Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,**											
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**			**0**	**0**			**0**	**0**			**0**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 23.78**	**$ 4.07**	**$ 54.02**	**$ 6.29**	**$ 21.89**	**$ 4.07**	**$ 50.94**	**$ -**	**$ 59.66**	**$ 4.44**	**$ 50.55**
8		**TOTAL CLINICAL STAFF TIME**	**34.0**	**11.0**	**53.0**	**17.0**	**29.0**	**11.0**	**42.0**	**0.0**	**52.0**	**12.0**	**41.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**0.0**	**8.0**	**8.0**	**14.0**	**0.0**	**8.0**	**0.0**	**0.0**	**3.0**	**9.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**31.0**	**0.0**	**42.0**	**0.0**	**26.0**	**0.0**	**39.0**	**0.0**	**46.0**	**0.0**	**38.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**0.0**	**3.0**	**3.0**	**3.0**
106	**Supply Code**	**MEDICAL SUPPLIES**											
107		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 10.96**	**$ -**	**$ 34.16**	**$ -**	**$ 10.96**	**$ -**	**$ 34.67**	**$ -**	**$ 39.01**	**$ -**	**$ 34.67**
108	SA041	pack, basic injection			1				1		1		1
109	SA048	pack, minimum multi-specialty visit	1		1		1				1		
110	SA051	pack, pelvic exam	1		1		1						
111	SC040	needle, Kopan			1								
112	SK075	skin marking pen, sterile (Skin Skribe)									1		
113	SH023	chlorhexidine 0.12% (Peridex)									1		
114	SC028	needle, 18-26g 1.5-3.5in, spinal											
115	SC034	needle, blunt tip											
116	SC057	syringe 5-6ml			1								
117	SH021	bupivacaine 0.25% inj (Marcaine)	10		5		10						
118	SB006	drape, non-sterile, sheet 40in x 60in	1				1						
119	SJ052	swab, procto 16in	2				2						
120	SJ043	povidone swabsticks (3 pack uou)	1				1						
121	1	Invoice #1850307197	1				1						
122	SJ053	swab-pad, alcohol											
123	SG021	bandage, strip 0.75in x 3in (Bandaid)											
124	SG056	gauze, sterile 4in x 4in (10 pack uou)									**2**		
125	SH047	lidocaine 1%-2% inj (Xylocaine)									15		
126	SD050	electrode needle, injectable (Myoject)							1		1		1
127	SH022	bupivacaine 0.5% inj (Marcaine)							30		15		30
128	SC038	needle, epidural (RK)											
129	SC053	syringe 20ml									2		
130	SC051	syringe 10-12ml											
131	SA088	tray, surgical skin prep, sterile									**0**		
132	SD269	Grounding pad											
133	SB019	drape-towel, sterile 18in x 26in											
134	SC029	needle, 18-27g											
135	SG021	bandage, strip 0.75in x 3in (Bandaid)											
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)									**0**		
137	SB005	cover-condom, transducer or ultrasound probe											
138	SJ033	lubricating jelly (Surgilube)											
139	SM012	disinfectant spray (Transeptic)											
140	SM021	sanitizing cloth-wipe (patient)											
141		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*											
143	**Equipment Code**	**EQUIPMENT**											
144		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 0.24**	**$ -**	**$ 0.26**	**$ -**	**$ 0.20**	**$ -**	**$ 0.73**	**$ -**	**$ 1.42**	**$ -**	**$ 0.71**
145	EF023	table, exam	28		87		23		39		29		38
146	EQ168	light, exam	28				23						
147	EF027	table, instrument, mobile	28				23						
148	EQ211	pulse oximeter w-printer											
149	EF008	chair with headrest, exam, reclining											
150	EQ184	nerve stimulator (eg, for nerve block)							39		29		38
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)							39		**89**		38
152	EF018	stretcher											
153	EF015	mayo stand									29		
154	ED050	Technologist PACS workstation											
155	ED053	Professional PACS Workstation											
156	EQ250	ultrasound unit, portable											
157													
158		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*											

	A	B	AX	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH
1	RUC Practice Expense Spreadsheet		RENT	RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2	REVISED	*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.	447	64447		64449		64449		64450		64450	
3		RUC Collaboration Website	anesthetic	Injection(s),		Injection, anesthetic		Injection(s),		Injection, anesthetic		Injection(s),	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,	oral nerve, gle	anesthetic agent(s) and/or steroid;femoral nerve, single		agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)		anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion		agent; other peripheral nerve or branch		anesthetic agent(s) and/or steroid; other peripheral nerve or branch	
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	0			0	0			0	0		
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ 36.67	$ 4.44	$ -	$ 2.22	$ -	$ 4.44	$ 33.11	$ 6.29	$ 35.39	$ 4.44
8		TOTAL CLINICAL STAFF TIME	0.0	41.0	12.0	0.0	6.0	0.0	12.0	50.0	17.0	47.0	12.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	3.0	9.0	0.0	0.0	0.0	9.0	8.0	14.0	3.0	9.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	35.0	0.0	0.0	6.0	0.0	0.0	39.0	0.0	41.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	3.0	3.0	0.0	0.0	0.0	3.0	3.0	3.0	3.0	3.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE	$ -	$ 15.17	$ 4.44	$ -	$ 2.22	$ -	$ 4.44	$ 18.50	$ 6.29	$ 17.39	$ 4.44
13		PRE-SERVICE PERIOD											
14		Start: Following visit when decision for surgery or pr											
15	CA001	Complete pre-service diagnostic and referral forms			0				0		3		0
16	CA002	Coordinate pre-surgery services (including test results)			3				3				3
17	CA003	Schedule space and equipment in facility			3				3		3		3
18	CA004	Provide pre-service education/obtain consent		0	0				0	5	5	0	0
19	CA005	Complete pre-procedure phone calls and prescription		3	3				3	3	3	3	3
20	CA006	Confirm availability of prior images/studies											
21	CA007	Review patient clinical extant information and											
22	CA008	Perform regulatory mandated quality assurance											
29		End: When patient enters office/facility for surgery/pr											
30		SERVICE PERIOD											
31		Start: When patient enters office/facility for surgery/p											
32		Pre-Service (of service period)											
33	CA009	Greet patient, provide gowning, ensure appropriate		3						3		3	
34	CA010	Obtain vital signs		5						5		5	
35	CA011	Provide education/obtain consent		3								3	
36	CA012	Review requisition, assess for special needs											
37	CA013	Prepare room, equipment and supplies		0						5		2	
38	CA013	Prepare room, equipment and supplies											
39	CA014	Confirm order, protocol exam											
40	CA015	Setup scope (nonfacility setting only)											
41	CA016	Prepare, set-up and start IV, initial positioning and		0						2		2	
42	CA016	Prepare, set-up and start IV, initial positioning and											
43	CA017	Sedate/apply anesthesia											
50		Intra-service (of service period)											
51	CA018	Assist physician or other qualified healthcare		6			0			0		5	
52	CA019	Assist physician or other qualified healthcare								3			
53	CA020	Assist physician or other qualified healthcare											
54	CA021	Perform procedure/service---NOT directly related to											
61	CA021	Perform procedure/service---NOT directly related to											
62		Post-Service (of service period)											
63	CA022	Monitor patient following procedure/service,		15						15		15	
64	CA023	Monitor patient following procedure/service, no											
65	CA024	Clean room/equipment by clinical staff		0						3		3	
66	CA024	Clean room/equipment by clinical staff											
67	CA025	Clean scope											
68	CA026	Clean surgical instrument package											
69	CA027	Complete post-procedure diagnostic forms, lab and x-											
70	CA028	Review/read post-procedure x-ray, lab and pathology											
71	CA029	Check dressings, catheters, wounds		1						1		1	
72	CA030	Technologist QC's images in PACS, checking for all											
73	CA031	Review examination with interpreting MD/DO											
74	CA031	Review examination with interpreting MD/DO											
75	CA032	Scan exam documents into PACS. Complete exam in											
76	CA032	Scan exam documents into PACS. Complete exam in											
77	CA033	Perform regulatory mandated quality assurance											
78	CA034	Document procedure (nonPACS) (e.g. mandated											
79	CA035	Review home care instructions, coordinate		2						2		2	
80	CA036	Discharge day management		n/a		n/a	6	n/a		n/a		n/a	
87		End: Patient leaves office											
88		POST-SERVICE PERIOD											
89		Start: Patient leaves office/facility											
90	CA037	Conduct patient communications		3	3				3	3	3	3	3
91	CA038	Coordinate post-procedure services											
92		*Office visits: List Number and Level of Office Visits*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
93		99211 16 minutes											
94		99212 27 minutes											
95		99213 36 minutes											
96		99214 53 minutes											
97		99215 63 minutes											
98	CA039	Post-operative visits (total time)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
105		End: with last office visit before end of global period											

	A	B	AX	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH
1	RUC Practice Expense Spreadsheet		RENT	RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2	REVISED	*Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.	447	64447		64449		64449		64450		64450	
3		RUC Collaboration Website	anesthetic oral nerve, gle	Injection(s), anesthetic agent(s) and/or steroid;femoral nerve, single		Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)		Injection(s), anesthetic agent(s) and/or steroid; lumbar plexus, posterior approach, continuous infusion		Injection, anesthetic agent; other peripheral nerve or branch		Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	
4	Clinical Activity Code	Meeting Date: October 2018 Tab: 9 Somatic Nerve Injection Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,											
5		LOCATION	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	0			0	0			0	0		
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ 36.67	$ 4.44	$ -	$ 2.22	$ -	$ 4.44	$ 33.11	$ 6.29	$ 35.39	$ 4.44
8		TOTAL CLINICAL STAFF TIME	0.0	41.0	12.0	0.0	6.0	0.0	12.0	50.0	17.0	47.0	12.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	3.0	9.0	0.0	0.0	0.0	9.0	8.0	14.0	3.0	9.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	35.0	0.0	0.0	6.0	0.0	0.0	39.0	0.0	41.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	0.0	3.0	3.0	0.0	0.0	0.0	3.0	3.0	3.0	3.0	3.0
106	Supply Code	MEDICAL SUPPLIES											
107		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ 20.34	$ -	$ -	$ -	$ -	$ -	$ 14.23	$ -	$ 16.72	$ -
108	SA041	pack, basic injection		1						1		1	
109	SA048	pack, minimum multi-specialty visit		1						1		1	
110	SA051	pack, pelvic exam											
111	SC040	needle, Kopan											
112	SK075	skin marking pen, sterile (Skin Skribe)		1								1	
113	SH023	chlorhexidine 0.12% (Peridex)		1								1	
114	SC028	needle, 18-26g 1.5-3.5in, spinal											
115	SC034	needle, blunt tip											
116	SC057	syringe 5-6ml								1			
117	SH021	bupivacaine 0.25% inj (Marcaine)								5			
118	SB006	drape, non-sterile, sheet 40in x 60in											
119	SJ052	swab, procto 16in											
120	SJ043	povidone swabsticks (3 pack uou)											
121	1	Invoice #1850307197											
122	SJ053	swab-pad, alcohol											
123	SG021	bandage, strip 0.75in x 3in (Bandaid)											
124	SG056	gauze, sterile 4in x 4in (10 pack uou)		2								2	
125	SH047	lidocaine 1%-2% inj (Xylocaine)		5								5	
126	SD050	electrode needle, injectable (Myoject)											
127	SH022	bupivacaine 0.5% inj (Marcaine)		30								5	
128	SC038	needle, epidural (RK)											
129	SC053	syringe 20ml		2									
130	SC051	syringe 10-12ml		1								1	
131	SA088	tray, surgical skin prep, sterile		0								0	
132	SD269	Grounding pad											
133	SB019	drape-towel, sterile 18in x 26in											
134	SC029	needle, 18-27g											
135	SG021	bandage, strip 0.75in x 3in (Bandaid)											
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)		0								0	
137	SB005	cover-condom, transducer or ultrasound probe											
138	SJ033	lubricating jelly (Surgilube)											
139	SM012	disinfectant spray (Transeptic)											
140	SM021	sanitizing cloth-wipe (patient)											
141		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*											
143	Equipment Code	EQUIPMENT											
144		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ 1.16	$ -	$ -	$ -	$ -	$ -	$ 0.38	$ -	$ 1.27	$ -
145	EF023	table, exam		18						79		24	
146	EQ168	light, exam											
147	EF027	table, instrument, mobile											
148	EQ211	pulse oximeter w-printer											
149	EF008	chair with headrest, exam, reclining											
150	EQ184	nerve stimulator (eg, for nerve block)		0						79			
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)		78								84	
152	EF018	stretcher											
153	EF015	mayo stand		18								24	
154	ED050	Technologist PACS workstation											
155	ED053	Professional PACS Workstation											
156	EQ250	ultrasound unit, portable											
157													
158		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*											

	A	B	BI	BJ
1	**RUC Practice Expense Spreadsheet**		**REFERENCE**	
2	**REVISED**	***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.*** ***Please do not modify formulas in gray shaded cells*** ***Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**76942**	
3		***RUC Collaboration Website***	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device),	
4	**Clinical Activity Code**	**Meeting Date: October 2018** **Tab: 9 Somatic Nerve Injection** **Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,**		
5		**LOCATION**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 20.19**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**26.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**2.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**24.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE**	**$ 13.26**	**$ -**
13		**PRE-SERVICE PERIOD**		
14		**Start: Following visit when decision for surgery or pr**		
15	CA001	Complete pre-service diagnostic and referral forms		
16	CA002	Coordinate pre-surgery services (including test results)		
17	CA003	Schedule space and equipment in facility		
18	CA004	Provide pre-service education/obtain consent		
19	CA005	Complete pre-procedure phone calls and prescription		
20	CA006	Confirm availability of prior images/studies	2	
21	CA007	Review patient clinical extant information and		
22	CA008	Perform regulatory mandated quality assurance		
29		**End: When patient enters office/facility for surgery/pr**		
30		**SERVICE PERIOD**		
31		**Start: When patient enters office/facility for surgery/p**		
32		**Pre-Service (of service period)**		
33	CA009	Greet patient, provide gowning, ensure appropriate		
34	CA010	Obtain vital signs		
35	CA011	Provide education/obtain consent		
36	CA012	Review requisition, assess for special needs		
37	CA013	Prepare room, equipment and supplies		
38	CA013	Prepare room, equipment and supplies	2	
39	CA014	Confirm order, protocol exam		
40	CA015	Setup scope (nonfacility setting only)		
41	CA016	Prepare, set-up and start IV, initial positioning and		
42	CA016	Prepare, set-up and start IV, initial positioning and	2	
43	CA017	Sedate/apply anesthesia		
50		**Intra-service (of service period)**		
51	CA018	Assist physician or other qualified healthcare		
52	CA019	Assist physician or other qualified healthcare		
53	CA020	Assist physician or other qualified healthcare		
54	CA021	Perform procedure/service---NOT directly related to		
61	CA021	Perform procedure/service---NOT directly related to	15	
62		**Post-Service (of service period)**		
63	CA022	Monitor patient following procedure/service,		
64	CA023	Monitor patient following procedure/service, no		
65	CA024	Clean room/equipment by clinical staff		
66	CA024	Clean room/equipment by clinical staff	2	
67	CA025	Clean scope		
68	CA026	Clean surgical instrument package		
69	CA027	Complete post-procedure diagnostic forms, lab and x-		
70	CA028	Review/read post-procedure x-ray, lab and pathology		
71	CA029	Check dressings, catheters, wounds		
72	CA030	Technologist QC's images in PACS, checking for all		
73	CA031	Review examination with interpreting MD/DO		
74	CA031	Review examination with interpreting MD/DO	2	
75	CA032	Scan exam documents into PACS. Complete exam in		
76	CA032	Scan exam documents into PACS. Complete exam in	1	
77	CA033	Perform regulatory mandated quality assurance		
78	CA034	Document procedure (nonPACS) (e.g. mandated		
79	CA035	Review home care instructions, coordinate		
80	CA036	Discharge day management		
87		**End: Patient leaves office**		
88		**POST-SERVICE PERIOD**		
89		**Start: Patient leaves office/facility**		
90	CA037	Conduct patient communications		
91	CA038	Coordinate post-procedure services		
92		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**
93		99211 16 minutes		
94		99212 27 minutes		
95		99213 36 minutes		
96		99214 53 minutes		
97		99215 63 minutes		
98	CA039	Post-operative visits (total time)	**0.0**	**0.0**
105		**End: with last office visit before end of global period**		

	A	B	BI	BJ
1	**RUC Practice Expense Spreadsheet**		**REFERENCE**	
2	**REVISED**	***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.*** ***Please do not modify formulas in gray shaded cells*** ***Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**76942**	
3		***RUC Collaboration Website***	Ultrasonic guidance for needle placement (eg, biopsy, aspiration, injection, localization device),	
4	**Clinical Activity Code**	**Meeting Date: October 2018** **Tab: 9 Somatic Nerve Injection** **Specialty: American Society of Anesthesiologists, American Academy of Physical Medicine and Rehabilitation, American Academy of Neurology,**		
5		**LOCATION**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**		
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 20.19**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**26.0**	**0.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**2.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**24.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**0.0**	**0.0**
106	**Supply Code**	**MEDICAL SUPPLIES**		
107		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 2.71**	**$ -**
108	SA041	pack, basic injection		
109	SA048	pack, minimum multi-specialty visit		
110	SA051	pack, pelvic exam		
111	SC040	needle, Kopan		
112	SK075	skin marking pen, sterile (Skin Skribe)		
113	SH023	chlorhexidine 0.12% (Peridex)		
114	SC028	needle, 18-26g 1.5-3.5in, spinal		
115	SC034	needle, blunt tip		
116	SC057	syringe 5-6ml		
117	SH021	bupivacaine 0.25% inj (Marcaine)		
118	SB006	drape, non-sterile, sheet 40in x 60in		
119	SJ052	swab, procto 16in		
120	SJ043	povidone swabsticks (3 pack uou)		
121	1	Invoice #1850307197		
122	SJ053	swab-pad, alcohol		
123	SG021	bandage, strip 0.75in x 3in (Bandaid)		
124	SG056	gauze, sterile 4in x 4in (10 pack uou)		
125	SH047	lidocaine 1%-2% inj (Xylocaine)		
126	SD050	electrode needle, injectable (Myoject)		
127	SH022	bupivacaine 0.5% inj (Marcaine)		
128	SC038	needle, epidural (RK)		
129	SC053	syringe 20ml		
130	SC051	syringe 10-12ml		
131	SA088	tray, surgical skin prep, sterile		
132	SD269	Grounding pad		
133	SB019	drape-towel, sterile 18in x 26in		
134	SC029	needle, 18-27g		
135	SG021	bandage, strip 0.75in x 3in (Bandaid)		
136	SJ081	swab, patient prep, 1.5 ml (chloraprep)		
137	SB005	cover-condom, transducer or ultrasound probe	1	
138	SJ033	lubricating jelly (Surgilube)	4	
139	SM012	disinfectant spray (Transeptic)	10	
140	SM021	sanitizing cloth-wipe (patient)	2	
141		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*		
143	**Equipment Code**	**EQUIPMENT**		
144		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 4.22**	**$ -**
145	EF023	table, exam		
146	EQ168	light, exam		
147	EF027	table, instrument, mobile		
148	EQ211	pulse oximeter w-printer		
149	EF008	chair with headrest, exam, reclining		
150	EQ184	nerve stimulator (eg, for nerve block)		
151	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)		
152	EF018	stretcher		
153	EF015	mayo stand		
154	ED050	Technologist PACS workstation	15	
155	ED053	Professional PACS Workstation	19	
156	EQ250	ultrasound unit, portable	24	
157				
158		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Harvard Valued – Utilization Over 30,000

April 2016

Injection Anesthetic Agent

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified.

64418 Injection, anesthetic agent; suprascapular nerve
The RUC reviewed the survey results from 139 physicians for CPT code 64418 and determined that the survey median and 25th percentile work RVUs did not adequately account for the work required to perform this service. Therefore, the RUC recommends crosswalking code 64418 to code 20611 *Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting* (work RVU = 1.10 and 10 minutes intra-service time).

The RUC reviewed the pre-service time for CPT code 66418 and agreed that pre-time package 6A (Procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect) is appropriate. However, the RUC did not agree with the specialties recommended pre-time inputs and determined that the pre-time needed to be decreased further to account for overlap in time with an Evaluation and Management service that typically reported with this service. Therefore, the RUC recommends 6 minutes of evaluation time, 3 minutes of positioning time, 3 minutes of scrub dress and wait time, 10 minutes intra-service time and 10 minutes immediate post-service time. The RUC confirmed that 10 minutes of immediate post-service time is required to assess the patient for pain relief, respiratory, hemodynamic, mental orientation, and extremity vascular status changes; required as a result of the risk of intra-vascular injection or pneumothorax. The physician also assesses any impact on the patient's activities of daily living including eating, bathing, brushing teeth and hair and overhead activities. The physician performs both strength testing and functional assessments to evaluate weakness in the limb that was injected as a result of anesthetic response. The RUC noted that the majority of nerve block codes that were recently reviewed include 10 minutes of immediate post-service time.

The RUC noted that the recommended work RVU of 1.10 and 32 minutes of total time for CPT 66418 is relative compared to the top two key reference services 64450 *Injection, anesthetic agent; other peripheral nerve or branch* (work RVU = 0.75 and 20 minutes total time) and 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU = 1.27 and 35 minutes of total time). The RUC noted that the recommendation is comparable to other nerve block codes 64405 *Injection, anesthetic agent; greater occipital nerve* (work RVU = 0.94 and 22 minutes total time) and 64415 *Injection, anesthetic agent; brachial plexus, single* (work RVU = 1.48 and 44 minutes total time). **The RUC recommends a work RVU of 1.10 for CPT code 64418.**

Practice Expense
One minor modification was made to correct the equipment minutes calculation. The Practice Expense Subcommittee reviewed the clinical staff time inputs to ensure that there were no duplicative times with the Evaluation and Management visit. The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.

Work Neutrality
The RUC's recommendation for this code will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
64418	Injection, anesthetic agent; suprascapular nerve	000	1.10

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 64418 Tracking Number

Original Specialty Recommended RVU: **1.20**
Presented Recommended RVU: **1.20**
RUC Recommended RVU: **1.10**

Global Period: 000

CPT Descriptor: Injection, anesthetic agent; suprascapular nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 52-year-old woman with a frozen shoulder is unable to tolerate physical therapy due to pain. She is referred for a suprascapular nerve block to providepain relief so that she can undergo physical therapy.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Moderate Sedation

Is moderate sedation inherent to this procedure in the Hospital/ASC setting? No
Percent of survey respondents who stated moderate sedation is typical in the Hospital/ASC setting? 38%

Is moderate sedation inherent to this procedure in the office setting? No
Percent of survey respondents who stated moderate sedation is typical in the office setting? 15%

Description of Pre-Service Work: Review records, communicate with other professionals, patient, and family; and obtain consent. Perform a focused History and Physical examination of the patient to confirm indications for procedure, potential contraindications, existing neurological deficits, and bleeding disorders. The pre-operative work also includes dressing, scrubbing, and waiting before the procedure; preparing the patient and equipment for the procedure; obtaining vital signs and positioning the patient in the sitting position.

Description of Intra-Service Work: Universal protocol is followed with confirmation of patient identifiers, procedure site, and laterality. The injection site overlying the scapular notch is identified. After sterile preparation of the skin, a local anesthetic skin wheal is placed at the site of injection. A needle is inserted toward the scapular notch. Once correct needle position is achieved, the needle is aspirated to confirm the absence of blood or air. Following negative aspiration, a small test-dose of local anesthetic is administered. The patient is queried about symptoms of intravascular local anesthetic injection. If there are no signs or symptoms of intravascular injection, the planned local anesthetic volume is injected in incremental doses with frequent aspiration to avoid intravascular injection. After completion of the injection, the needle is removed. The patient is evaluated for the initial effects of the block by physical examination to determine if the patient is developing weakness or numbness, and is evaluated for relief of pain in the expected nerve distribution.

Description of Post-Service Work: The patient is observed post-procedure for pain relief, respiratory, hemodynamic, mental orientation, or extremity vascular status changes. In addition, the limb that has received the nerve block is protected to prevent injury. The patient is provided education on the signs and symptoms of potential complications and the need to protect the anesthetized extremity. The physician communicates findings with the patient and other professionals (including written and telephone reports and orders).

SURVEY DATA

RUC Meeting Date (mm/yyyy)	05/2016				
Presenter(s):	Marc Leib, MD, Richard Rosenquist, MD, Matthew Grierson, MD, Barry Smith, MD				
Specialty(s):	ASA, AAPM&R, AAPM				
CPT Code:	64418				
Sample Size:	3500	**Resp N:**	139	**Response:** 3.9 %	
Description of Sample:	Random Sample				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	3.00	**7.00**	20.00	1300.00
Survey RVW:	0.70	1.00	**1.20**	1.45	4.00
Pre-Service Evaluation Time:			**17.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	5.00	**10.00**	13.00	45.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6A-NF Proc w local/topical anes care req wait time

CPT Code:	64418	**Recommended Physician Work RVU: 1.10**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**6.00**	**17.00**	**-11.00**
Pre-Service Positioning Time:		**3.00**	**1.00**	**2.00**
Pre-Service Scrub, Dress, Wait Time:		**3.00**	**5.00**	**-2.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64450	000	0.75	**RUC Time**

CPT Descriptor Injection, anesthetic agent; other peripheral nerve or branch

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64486	000	1.27	**RUC Time**

CPT Descriptor Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
30901	000	1.10	**RUC Time**	108,336

CPT Descriptor 1 Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
12013	000	1.22	**RUC Time**	51,998

CPT Descriptor 2 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source
40490	000	1.22	**RUC Time**

CPT Descriptor Biopsy of lip

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by the mean) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 39 **% of respondents:** 28.0 **%**

Number of respondents who choose 2nd Key Reference Code: 31 **% of respondents:** 22.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 64418	Top Key Reference CPT Code: 64450	2nd Key Reference CPT Code: **64486**
Median Pre-Service Time	12.00	10.00	15.00
Median Intra-Service Time	10.00	5.00	10.00
Median Immediate Post-service Time	10.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**32.00**	**20.00**	**35.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Intensity & Complexity Rating Scale: (much less= -2.00, somewhat less= -1.00, identical= 0.00, somewhat more= 1.00, much more= 2.00)

	Top Key Ref Code	2nd Key Ref Code
Mental Effort and Judgment (Mean)		
The number of possible diagnosis and/or the number of management options that must be considered	0.23	0.29
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	0.26	0.29
Urgency of medical decision making	0.00	-0.03
Technical Skill/Physical Effort (Mean)		
Technical skill required	0.46	0.55
Physical effort required	0.15	0.13
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	0.21	0.19

Outcome depends on the skill and judgment of physician	0.38	0.42
Estimated risk of malpractice suit with poor outcome	0.28	0.29

INTENSITY/COMPLEXITY MEASURES	**Top Key Ref Code**	**2nd Key Ref Code**
Time Segment (Mean)		
Overall intensity/complexity	0.41	0.29

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

In October 2015, AMA staff re-ran the Harvard valued codes with utilization over 30,000 based on 2014 Medicare claims data and this service was identified. The RUC determined that this service was to be placed on the next level of interest form to survey for April 2016.

Survey Sample and Process

The survey request was sent to a random selection from the membership database of the American Academy of Physician Medicine & Rehabilitation (AAPM&R). The American Society of Anesthesiologists (ASA) took a random sample of subspecialty pain medicine doctors from the ASA membership database. The standard RUC survey was conducted using a vignette drafted by the societies involved since 64418 had not previously been RUC reviewed. The Research Subcommittee reviewed and approved the vignette.

Pre-Service Time Package 6A

We recommend pre-time package 6A (NF Procedure w local/topical anesthesia care requiring wait time for anesthesia to take effect) as this procedure is performed in the physician's office 89% of the time according to the 2014 Medicare data. We recommend reducing the package pre-service evaluation time from 17 minutes to 8 minutes to account for overlap in time with an E/M service that is reported more than 50% of the time with 64418 on the same day. We also recommend increasing the package pre-service positioning time from 1 minute to 3 minutes. This is a reduction from the survey respondents' 5 minutes, as the Expert Panel indicated that 5 minutes overstated the positioning time, while the standard 1 minute in the pre-time package underestimates the time needed to position the patient. Additional positioning time is necessary because there is increased difficulty in identifying the target injection site, requiring manipulation of the patient's position to achieve the appropriate outcome. The Expert Panel agreed that the standard 5 minute scrub, dress and wait time in the pre-service package is appropriate.

Post-Service Time Package

We recommend post-service time package 7A (Local/Simple Procedure). We recommend reducing the package post-time from 18 minutes to 10 minutes, which corresponds with our survey data. In the post-service period the physician returns to the room following the initial injection to evaluate the patient for pain relief, respiratory, hemodynamic, mental orientation, and extremity vascular status changes; required as a result of the risk of intra-vascular injection or pneumothorax. The physician must proceed with caution to protect the shoulder post injection as an injury to the suprascapular nerve will have an impact on the patient's activities of daily living including eating, bathing, brushing teeth and hair and overhead activities. Both strength testing and functional assessments are performed to evaluate

weakness in the limb that was injected as a result of anesthetic response. The physician then evaluates for appropriateness of functional bracing of the shoulder.

Key Reference Codes

The recommended work RVU of 1.20 for 64418 fits well above the top key reference service (64450), since 64418 is more difficult to palpate the vessels around the suprascapular notch (compared to the posterior tibial vessels). Also, an injury to the suprascapular nerve will have a much greater impact on the patient than an injury to the posterior tibial nerve at the level of the ankle. It also fits well just below the second key reference code (64486). TAP block includes and is typically performed with image guidance. It also fits well with other injection codes and other codes in the RBRVS with similar IWPUTs, total time, and intra time.

MPC Comparison

MPC	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	1.07	0.068	24	7	12	5
30901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method	1.10	0.081	26	11	10	5
64418	**Injection, anesthetic agent; suprascapular nerve**	**1.10**	**0.065**	**32**	**12**	**10**	**10**
40490	Biopsy of lip	1.22	0.058	34	14	15	5
12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm	1.22	0.064	27	7	15	5

Other Comparison Codes

Code	Descriptor	RVW	IWPUT	Total Time	PRE	INTRA	POST
12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less	1.07	0.068	24	7	12	5
12002	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.6 cm to 7.5 cm	1.14	0.059	27	7	15	5
64418	**Injection, anesthetic agent; suprascapular nerve**	**1.10**	**0.065**	**32**	**12**	**10**	**10**
40490	Biopsy of lip	1.22	0.058	34	14	15	5
49082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance	1.24	0.065	40	20	10	10
67505	Retrobulbar injection; alcohol	1.27	0.078	35	20	10	5
64486	Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)	1.27	0.078	35	15	10	10

Recommendation

We recommend a work RVU of 1.20 for 64418. This value maintains the RUC and specialty accepted intensity/complexity rank order and relativity for code 64418 with many other injections codes requiring 10 minutes of intra-service time.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) Typically reported with an E&M service.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. For Medicare patients, 64418 is typically reported with an E&M service.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64418

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Sometimes

Specialty Physicial Medicine and Rehabiliation How often? Sometimes

Specialty Intervential Pain Management & Pain Management How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 92955
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency is estimated at 3 times Medicare frequency.

Specialty Anesthesiology Frequency 26588 Percentage 28.60 %

Specialty Physicial Medicine and Rehabilitation Frequency 11807 Percentage 12.70 %

Specialty Interventional Pain Management & Pain Medicine Frequency 20590 Percentage 22.15 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 30,985 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2014 Data RUC Database

Specialty Anesthesiology Frequency 8862 Percentage 28.60 %

Specialty Physicial Medicine and Rehabilitation Frequency 3957 Percentage 12.77 %

Specialty Interventional Pain Management and Pain Medicine Frequency 6865 Percentage 22.15 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64418

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Injection Anesthesia Agent (Suprascapular)

TAB: 28

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	FAC-obs 26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57
1st REF	64450	Injection, anesthetic agent; othe	48	0.083			0.75			20	10	0	0			5			5																			
2nd REF	64486	Transversus abdominis plane (TAP) bl		0.078			1.27			35	5	5	5			10			10																			
CURRENT	64418	Injection, anesthetic agent; suprascap		0.041			1.32			44	13	0	0			18			13																			
SVY	64418	Injection, anesthetic agent; supr	139	0.044	0.70	1.00	1.20	1.45	4.00	47	17	5	5	1	5	10	13	45	10																			
REC	64418	Injection, anesthetic agent; supr	139	0.065			1.10			32	6	3	3			10			10																			

28
Tab Number

Injection Anesthetic Agent (64418)
Issue

64418
Code Range

Attestation Statement

This form needs to be completed by any **RUC Advisor** whose specialty society is developing a recommendation to be reviewed by the RUC.

As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)

Signature

Marc Leib, MD, JD
Printed Signature

American Society of Anesthesiologists
Specialty Society

April 4, 2016
Date

28
Tab Number

Injection Anesthetic Agent (64418)
Issue

64418
Code Range

Attestation Statement

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Signature

Richard Rosenquist, MD
Printed Signature

American Society of Anesthesiologists
Specialty Society

April 4, 2016
Date

28
Tab Number

Injection Anesthetic Agent (64418)
Issue

64418
Code Range

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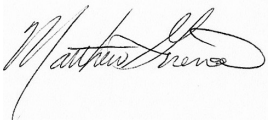

Signature

Matthew Grierson, MD
Printed Signature

American Academy of Physical Medicine & Rehabilitation
Specialty Society

April 4, 2016
Date

28
Tab Number

Injection Anesthetic Agent (64418)
Issue

64418
Code Range

Attestation Statement

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Signature

Barry Smith, MD
Printed Signature

American Academy of Physical Medicine & Rehabilitation
Specialty Society

April 4, 2016
Date

28
Tab Number

Injection Anesthetic Agent (64418)
Issue

64418
Code Range

Attestation Statement

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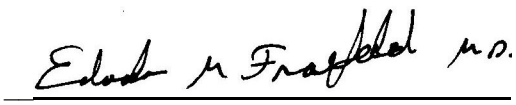
As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge. As a RUC advisor, I acknowledge that violations would be addressed by the executive committee (i.e., RUC Chair , AMA Representative and Alternate AMA Representative.)



Signature

Eduardo Fraifeld
Printed Signature

American Academy of Pain Medicine
Specialty Society

April 5, 2016
Date

CPT Code: 64418
Specialty Society('s) ASA, AAPM&R, AAPM

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Facility Direct Inputs

CPT Long Descriptor: Injection, anesthetic agent; suprascapular nerve

Global Period: 000 Meeting Date: April 2016

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The Advisors from the participating specialties reviewed the current PE details for 64418 and made adjustments as appropriate.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: Current inputs for 64418 are used as reference.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: N/A

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: N/A

5. Please describe in detail the clinical activities of your staff: N/A

Pre-Service Clinical Labor Activities:

Intra-Service Clinical Labor Activities:

Post-Service Clinical Labor Activities:

CPT Code: 64418
Specialty Society('s) ASA, AAPM&R and AAPM

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation
Non Facility Direct Inputs

CPT Long Descriptor: Injection, anesthetic agent; suprascapular nerve

Global Period: 000 Meeting Date: April 2016

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society Practice Expense Committee: The Advisors from the participating specialties reviewed the current PE details for 64418 and made adjustments as appropriate.

2. You must provide reference code(s) for comparison on your spreadsheet. **If the code you are making recommendations on is a revised code you must use the current PE direct inputs for the code as your comparison.** You must provide an explanation for the selection of reference codes. Reference Code Rationale: Current inputs for 64418 are used as reference.

3. If you are recommending more minutes than the PE Subcommittee standards you must provide evidence to justify the time: Not applicable.

4. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence:

Supplies

The Expert Panel that reviewed the supplies did not believe that this procedure required a pack, minimum multi-specialty visit.

Additionally, the Panel believed that the pack, basic injection, did not accurately reflect the supplies need for this procedure and we are recommending only the inputs that are necessary to perform this procedure in a sterile environment including:

- 5ml - bupivacaine 0.25% inj (Marcaine)
- 1 - cap, surgical
- 1 - mask, surgical
- 1 - gloves, sterile
- 1 - drape, sterile barrier 16in x 29in
- 1 - drape, sterile, for Mayo stand
- 1 - swab, patient prep, 1.5 ml (chloraprep)
- 1 - needle, 18-27g
- 1 - needle, 18-26g 1.5-3.5in, spinal
- 2 - syringe 5-6ml
- 5ml - lidocaine 1%-2% inj (Xylocaine)
- 1 - gauze, sterile 4in x 4in
- 1 - bandage, strip 0.75in x 3in (Bandaid)

Equipment

Mayo stand - The removable instrument tray (mayo stand) is set adjacent to the injection; it provides a place for sterile instruments and supplies used during the injection.

Light, exam – The exam light is used to accurately visualize the injection site.

5. Please describe in detail the clinical activities of your staff:

Pre-Service Period Clinical Labor Activities:

Service Period Clinical Labor Activities:

Pre-service
During the service period clinical staff will provide pre-service education, prepare the room, equipment, and supplies, and prepare and position patient. The 2 minutes included with an E/M service does not include setting up supplies for the injection which will include preparing the exam light and mayo stand with syringes, needles, drapes, and etc. to maintain a sterile field; 5 minutes additional time is recommended for these activities.

Intra-service
Clinical staff assists the physician for 100% of the intra-service time.

Post-service
Clinical staff provides 1:1 monitoring of the patient following the injection to monitor the patient for vasovagal response, mental status, and check vital signs. Clinical staff also fits the patient for the bracing and demonstrate proper use of the device. Finally, clinical staff will check the injection site, provide written and verbal post-injection and follow-up instructions on care of the injection site and activity restrictions.

Post-Service Clinical Labor Activities:

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2	***Please note: If a supply has a purchase price of $100 or more please bold the item name and CMS code.**			**64418**		**64418**	
3	**Meeting Date: April 2016** **Tab: 28** **Specialty: ASA, AAPM&R, AAPM**	**CMS Code**	**Staff Type**	Injection, anesthetic agent; suprascapular nerve		Injection, anesthetic agent; suprascapular nerve	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**0**	**0**	**0**	**0**
6	**TOTAL CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**56.0**	**17.0**	**20.0**	**0.0**
7	**TOTAL PRE-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**8.0**	**14.0**	**0.0**	**0.0**
8	**TOTAL SERVICE PERIOD CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**45.0**	**0.0**	**20.0**	**0.0**
9	**TOTAL POST-SERV CLINICAL LABOR TIME**	**L037D**	**RN/LPN/MTA**	**3.0**	**3.0**	**0.0**	**0.0**
10	**PRE-SERVICE**						
11	**Start: Following visit when decision for surgery or procedure made**						
12	Complete pre-service diagnostic & referral forms			**0**	**3**	**0**	**0**
13	Coordinate pre-surgery services			**0**	**0**	**0**	**0**
14	Schedule space and equipment in facility			**0**	**0**	**0**	**0**
15	Provide pre-service education/obtain consent			**5**	**5**	**0**	**0**
16	Follow-up phone calls & prescriptions			**3**	**3**	**0**	**0**
17	Other Clinical Activity - *specify:*			**0**	**0**	**0**	**0**
18	**End: When patient enters office/facility for surgery/procedure**						
19	**SERVICE PERIOD**						
20	**Start: When patient enters office/facility for surgery/procedure:**						
21	Greet patient, provide gowning, ensure appropriate medical records are available			**3**	**0**	**0**	**0**
22	Obtain vital signs			**3**	**0**	**0**	**0**
23	Provide pre-service education/obtain consent	**L037D**	**RN/LPN/MTA**	**0**	**0**	**3**	**0**
24	Prepare room, equipment, supplies	**L037D**	**RN/LPN/MTA**	**2**	**0**	**2**	**0**
26	Prepare and position patient/ monitor patient/ set up IV	**L037D**	**RN/LPN/MTA**	**2**	**0**	**0**	**0**
28	**Intra-service**						
29	Assist physician in performing procedure	**L037D**	**RN/LPN/MTA**	**12**	**0**	**10**	**0**
30	**Post-Service**			**0**	**0**		
32	Monitor pt. following procedure/check tubes, monitors, drains, multitasking 1:4 (not related to moderate sedation)			**0**	**0**	**0**	**0**
33	Monitor pt. following procedure/check tubes, monitors, drains, no multitasking 1:1 (not related to moderate sedation)	**L037D**	**RN/LPN/MTA**	**15**	**0**	**3**	**0**
34	Clean room/equipment by physician staff	**L037D**	**RN/LPN/MTA**	**3**	**0**	**0**	**0**
39	Check dressings & wound/ home care instructions /coordinate office visits /prescriptions	**L037D**	**RN/LPN/MTA**	**3**	**0**	**2**	**0**
44	**End: Patient leaves office**						
45	**POST-SERVICE Period**						
46	**Start: Patient leaves office/facility**						
47	Conduct phone calls/call in prescriptions			**3**	**3**	**0**	**0**
56	**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G
1				REFERENCE CODE			
2	***Please note: If a supply has a purchase price of $100 or more please bold the item name and CMS code.**			64418		64418	
3	**Meeting Date: April 2016 Tab: 28 Specialty: ASA, AAPM&R, AAPM**	**CMS Code**	**Staff Type**	Injection, anesthetic agent; suprascapular nerve		Injection, anesthetic agent; suprascapular nerve	
4	**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**
5	**GLOBAL PERIOD**			**0**	**0**	**0**	**0**
57	**MEDICAL SUPPLIES***	**CODE**	**UNIT**				
58	pack, minimum multi-specialty visit	SA048	pack	**1**	**0**	**0**	**0**
59	pack, basic injection	SA041	pack	**1**	**0**	**0**	**0**
60	syringe 10-12ml	SC051	item	**1**	**0**	**0**	**0**
61	electrode needle, injectable (Myoject)	SD050	item	**1**	**0**	**0**	**0**
62	bupivacaine 0.25% inj (Marcaine)	SH021	ml	**10**	**0**	**5**	**0**
63	cap, surgical	SB001	item	**0**	**0**	**1**	**0**
64	mask, surgical	SB033	item	**0**	**0**	**1**	**0**
65	gloves, sterile	SB024	pair	**0**	**0**	**1**	**0**
66	drape, sterile barrier 16in x 29in	SB007	item	**0**	**0**	**1**	**0**
67	drape, sterile, for Mayo stand	SB012	item	**0**	**0**	**1**	**0**
68	swab, patient prep, 1.5 ml (chloraprep)	SJ081	item	**0**	**0**	**1**	**0**
69	needle, 18-27g	SC029	item	**0**	**0**	**1**	**0**
70	needle, 18-26g 1.5-3.5in, spinal	SC028	item	**0**	**0**	**1**	**0**
71	syringe 5-6ml	SC057	item	**0**	**0**	**2**	**0**
72	lidocaine 1%-2% inj (Xylocaine)	SH047	ml	**0**	**0**	**5**	**0**
73	gauze, sterile 4in x 4in	SG055	item	**0**	**0**	**1**	**0**
74	bandage, strip 0.75in x 3in (Bandaid)	SG021	item	**0**	**0**	**1**	**0**
75	**EQUIPMENT**	**CODE**					
76	nerve stimulator (eg, for nerve block)	EQ184		**28**	**0**	**0**	**0**
77	table, exam	EF023		**88**	**0**	**20**	**0**
78	**mayo stand**	**EF015**		**0**	**0**	**20**	**0**
79	**light, exam**	**EQ168**		**0**	**0**	**20**	**0**
80							

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS 000-Day Global Typically Reported with an E/M

April 2017

Injection - Greater Occipital Nerve

In the Final Rule for 2017, CMS finalized the list of 000-day global services reported with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician, that have not been reviewed in the last five years with Medicare utilization greater than 20,000. CPT code 64405 was identified on this list.

The RUC reviewed the survey results from 175 physicians from four different specialties and determined that it was appropriate to maintain the current work RVU of 0.94, which also represents the survey 25th percentile. The specialty societies recommended pre-time package 5, but reduced the package evaluation time by one minute to account for overlap because this service is typically reported with an E/M on the same day. The post-service time was reduced by 5 minutes in accordance with the survey results. The RUC carefully examined potential overlap with E/M services included in CPT 64405 and further reduced the pre-service evaluation time by 1 minute to 5 minutes. In addition, the RUC reduced the positioning time by 2 minutes and removed the 3 minutes of pre-service time for scrub/dress/wait because local anesthetic is not typical prior to this procedure but is included in the injection itself. The RUC recommends 5 minutes evaluation time, 1 minute positioning time, 5 minutes of intra-service time, and 5 minutes of immediate post-service time.

The RUC compared the survey code to the top two key reference services 20526 *Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel* (work RVU = 0.94) and 20552 *Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)* (work RVU = 0.66) and noted that the current work RVU of the survey code is appropriately equal to carpal tunnel and higher than the other injections. The 2nd key reference code 20526 represents identical overall work and total time. For additional support, the RUC compared the survey code to several multi-specialty point of comparison CPT codes: 67820 *Correction of trichiasis; epilation, by forceps only* (work RVU = 0.71), 12001 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less* (work RVU = 0.84), 51720 *Bladder instillation of anticarcinogenic agent (including retention time)* (work RVU = 0.87) and 20527 *Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)* (work RVU = 1.00), and agreed that the survey 25th percentile of 0.94 places survey code 64405 in proper rank order. The RUC determined that the key reference services and comparable MPC codes support maintaining the current value for the survey code.

The RUC further agreed with the consensus of the specialty societies that the physician work for this service has not fundamentally changed since it was last reviewed in 2010 as part of the 4th Five-Year Review and recommends that the work RVU be maintained at the 25th percentile in accordance with the most recent survey. **The RUC recommends a work RVU of 0.94 for CPT code 64405.**

In addition, the RUC observed that there are inconsistencies in the Medicare Claims Processing Manual (Manual) related to reporting an E/M service on the same day as a minor procedure. While acknowledging the CMS staff citation from the manual, Chapter 12, Section 40.1, paragraph B, regarding reporting an E/M visit with a 000-day global code and the expectation that all of the focused evaluation work is included in the global period, the presenters noted that in two other sections of the same Manual chapter, the guidance provided is different. Specifically, Section 40.1 paragraph C and Section 40.2 paragraph A (#8) of the Manual confirm that it is permissible to report an E/M code on the same day as a minor surgical procedure when a significant, separately identifiable service is also performed. It is appropriate to append modifier 25 to the E/M code in instances where a significant, separately identifiable evaluation and management service is performed by same physician on the day of a procedure. The RUC also noted this Section of the Manual corresponds to CPT Modifier 25 instructions which state: "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported."

Practice Expense

The Practice Expense Subcommittee eliminated any clinical staff time and supplies that overlap with an evaluation and management service as the code is reported with an E/M more than 50% of the time. Additionally the RUC removed the exam light (EQ168) as it would not typically be used for this service and would not be in a standard room used for evaluation and management. The RUC recommends the direct practice expense inputs with modifications as reviewed and approved by the PE Subcommittee.

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
64405	Injection, anesthetic agent; greater occipital nerve	000	0.94 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64405 Tracking Number Original Specialty Recommended RVU: **0.94**
Presented Recommended RVU: **0.94**
Global Period: 000 Current Work RVU: **0.94** RUC Recommended RVU: **0.94**

CPT Descriptor: Injection, anesthetic agent; greater occipital nerve

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with frequent headaches and a normal neurologic examination has tenderness over the left occipital notch, where palpation triggers the pain. For both diagnostic and therapeutic purposes, an injection of local anesthetic and anti-inflammatory is recommended.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the patient's history to ensure she is suitable for the procedure (eg, not on anticoagulants and no history of allergic reaction to agents being used). Discuss the procedure with the patient, including alternatives and risks. Obtain informed consent. Palpate the upper cervical region near the lower extent of the skull dorsal to the mastoid process along the course of the greater occipital nerve and mark the proposed needle entry site. Examine the area of the scalp closely for infection. Clean the skin overlying the proposed injection site and prepare for injection. Prepare a syringe with a mix of a local anesthetic agent and an anti-inflammatory drug. Don gloves. Perform a pre-procedural time out.

Description of Intra-Service Work: Palpate the upper cervical region along the course of the greater occipital nerve. Penetrate the skin with the needle and inject the contents of the syringe along the course of the nerve following negative aspiration. Because of the significant vascularity of the scalp, make the injection with repeated, intermittent aspirations as the needle is repositioned along the course of the nerve.

Description of Post-Service Work: Apply pressure to the injection site to stop any bleeding after the injection, clean the injection area, and apply a bandage as necessary. Wait for the local anesthetic to work, inquiring if the patient has numbness in the distribution of the occipital nerve and if she has relief of her pain. Monitor the patient for any potential complications from the injection, including syncopal episode, intravascular injection, or evidence of distal particulate steroid injection. Discuss follow-up recommendations with the patient. Complete all appropriate medical records.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2017				
Presenter(s):	Kevin Kerber, MD; J. Mark Bailey, DO, PhD; Richard Rosenquist, MD; Neal Cohen, MD, MPH; Marc Leib, MD, JD; Matthew Grierson, MD; Gregory Polston, M.D				
Specialty(s):	American Academy of Neurology (AAN), American Academy of Pain Medicine (AAPM), American Academy of Physical Medicine & Rehabilitation (AAPM&R), American Society of Anesthesiologists (ASA)				
CPT Code:	64405				
Sample Size:	3856	**Resp N:**	175	**Response:** 4.5 %	
Description of Sample:	AAN: A sample of members from the Headach and Pain sections (current US members.) AAPM, AAPM&R, ASA: A sample of current US active members from each specialty society.				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	12.00	**25.00**	50.00	500.00
Survey RVW:	0.50	0.94	**1.00**	1.29	14.00
Pre-Service Evaluation Time:			**6.00**		
Pre-Service Positioning Time:			**3.00**		
Pre-Service Scrub, Dress, Wait Time:			**3.00**		
Intra-Service Time:	0.00	4.00	**5.00**	10.00	30.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

5-NF Proc w minimal anes care (if no deduct 1 min)

CPT Code:	64405	**Recommended Physician Work RVU: 0.94**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**7.00**	**-2.00**
Pre-Service Positioning Time:		**1.00**	**0.00**	**1.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**1.00**	**-1.00**
Intra-Service Time:		**5.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
20526	000	0.94	**RUC Time**

CPT Descriptor Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
20552	000	0.66	**RUC Time**

CPT Descriptor Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
12001	000	0.84	**RUC Time**	188,177

CPT Descriptor 1 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
67820	000	0.71	**RUC Time**	247,521

CPT Descriptor 2 Correction of trichiasis; epilation, by forceps only

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 92 **% of respondents:** 52.5 **%**

Number of respondents who choose 2nd Key Reference Code: 19 **% of respondents:** 10.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 64405	Top Key Reference CPT Code: 20526	2nd Key Reference CPT Code: **20552**
Median Pre-Service Time	6.00	6.00	11.00
Median Intra-Service Time	5.00	5.00	5.00
Median Immediate Post-service Time	5.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**16.00**	**16.00**	**21.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	2%	48%	43%	7%

Mental Effort and Judgment	Less	Identical	More
The number of possible diagnosis and/or the number of management options that must be considered	1%	34%	65%
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	10%	26%	64%
Urgency of medical decision making	7%	63%	30%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	62%	31%
Physical effort required	1%	76%	23%

Psychological Stress	Less	Identical	More
The risk of significant complications, morbidity and/or mortality	17%	25%	58%
Outcome depends on the skill and judgment of physician	9%	43%	48%
Estimated risk of malpractice suit with poor outcome	27%	32%	41%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	5%	42%	47%	5%

Mental Effort and Judgment	Less	Identical	More
The number of possible diagnosis and/or the number of management options that must be considered	16%	32%	53%
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	11%	53%	37%
Urgency of medical decision making	21%	63%	16%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	26%	68%
Physical effort required	5%	74%	21%

Psychological Stress	Less	Identical	More
The risk of significant complications, morbidity and/or mortality	11%	47%	42%
Outcome depends on the skill and judgment of physician	5%	37%	58%
Estimated risk of malpractice suit with poor outcome	16%	53%	32%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The American Society of Anesthesiologists (ASA), the American Academy of Pain Management (AAPM), the American Association of Physical Medicine & Rehabilitation (AAPM&R), and the American Academy of Neurology (AAN), conducted joint surveys of their memberships in March 2017 for CPT code 66405. A joint ASA, AAPM, AAPM&R and AAN expert panel ("joint panel") consisting of physician advisors reviewed the survey work and time data and developed recommendations through participation in conference calls and e-mail discussions.

There were 175 responses (82 from ASA, 16 from AAPM, 27 from AAPM&R, 50 from AAN) to the survey request with a median performance rate of 25; 97% of the survey respondents found the vignette to be typical. The RUC summary contains a breakout of ASA, AAPM, AAPM&R, and AAN respondents. The number of responses meet RUC criteria and the vast majority of respondents perform this service.

Code 64405 was identified by CMS in the 2017 final rule on a list of 000-day global services reported with an E/M 50 percent of the time or more, on the same day of service, same patient, by the same physician. 2015 data reflect that 64405 is billed with an office E/M 50% of the time. It was last reviewed in 2010 and currently has times of 7/5/10/22 and an RVU of 0.94.

First, the joint panel reviewed the survey data. The survey median and 25th percentile RVU were 1.00 and 0.94 respectively. The total survey time for this service of 22 minutes (12/5/5) which is identical to the current time. The panel agreed this was appropriate because the service has not changed since the last survey. Based on the preservice times, the panel selected preservice time package 5.

Next, the panel reviewed the key reference service 20526, Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel, which was chosen by more than half the respondents. It has times of 6/5/5/16 and an RVU of 0.94. This RVU is identical to the 25th percentile of the survey.

The panel also reviewed several comparator codes (noted in the table below) and agree that the survey 25 fifth percentile of 0.94 places 64405 in proper rank order to all the codes reviewed. Most importantly, 64405 is most similar to 20526 and 20527 in intensity and has longer total time than both.

CPT Code	Description	RVU	Pre-service time	Intra-service time	Post-service time	Total time	RUC review
20522	Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)	0.66	11	5	5	21	2016
67820	Correction of trichiasis; epilation, by forceps only	0.71	8	5	2	15	2005
12001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	0.84	7	10	5	22	2010
51720	Bladder instillation of anticarcinogenic agent (including retention time)	0.87	9	5	5	19	2016
20526	Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel	0.94	6	5	5	16	2002
64405	**Injection, anesthetic agent; greater occipital nerve**	**0.94**	**12**	**5**	**5**	**22**	**2010**
20527	Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)	1.00	8	5	5	18	2011

The joint panel note that 64405 is a more intense procedure than both 12001 and 67802 and has an identical total time to 12001 and is longer than 67820. Furthermore, the intensity / complexity measure responses from the survey further support the expert panel's recommendation of the survey 25th percentile because they are higher than both of the key reference services.

In summary, the main reference service and a review of other services with similar times and intensities, supports the survey 25th percentile RVU of 0.94. This is appropriate because the service has not changed since the last survey. This survey also provides strong validation for the 2010 survey. The joint panel reviewed the survey data by specialty and agreed it was remarkably consistent for both median time and median RVU across all specialties further supporting recommending the 25th percentile, thereby maintaining the current RVU.

Recommendations
In summary, we recommend the 25th percentile RVU of 0.94 and a preservice time of 12 minutes, an intra-service time of 5 minutes and a post-service time of 5 minutes for 64405.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) According to the 2015 Medicare same day billing occurrances claims data, 64405 is reported with an office E/M code 50% of the time.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64405

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Neurology How often? Commonly

Specialty Pain Management / Interventional PM How often? Commonly

Specialty Anesthesiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 439188
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. We anticiate 4 times the annual Medicare utilization; based on 2015 utilization data.

Specialty Neurology Frequency 166892 Percentage 38.00 %

Specialty Pain Management / Interventional PM Frequency 101014 Percentage 23.00 %

Specialty Anesthesiology Frequency 65880 Percentage 15.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 109,797 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2015 Medicare utilization data from the RUC database.

Specialty Neurology Frequency 41723 Percentage 38.00 %

Specialty Pain Management / Interventional PM Frequency 25254 Percentage 23.00 %

Specialty Anesthesiology Frequency 16470 Percentage 15.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64405

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Greater Occipital Nerve Block

TAB: 17

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST
1st REF	20526	Injection, therapeutic (eg, local anesthetic, corticosteroid),	92	0.139			0.94			16	6					5			5
2nd REF	20552	Injection(s); single or multiple trigger point(s), 1 or 2	19	0.075			0.66			21	5	1	5			5			5
CURRENT	64405	Injection, anesthetic agent; greater occipital nerve		0.112			0.94			22	7					5			10
SVY Total	64405	Injection, anesthetic agent; greater occipital nerve	175	0.132	0.50	0.94	1.00	1.29	14.00	22	6	3	3	0	4	5	10	30	5
REC	64405	Injection, anesthetic agent; greater occipital nerve		0.139			0.94			16	5	1				5			5

CPT Code:__64405_____
Specialty Society _AAN, AAPM, AAPM&R, ASA_____

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor: Injection, anesthetic agent; greater occipital nerve

Global Period:__000___ Meeting Date: ___April 2017_____

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel: The joint societies convened a panel of experts, including advisors who are familiar with the service. The panel of experts reviewed and collaborated via email and phone call to review existing direct practice expense inputs for code 64405 and the key reference code, 20526. Based on this review and its expertise, the panel made modifications as necessary. The panel of experts is recommending a reduced total clinical staff time stemming in large part from the fact that we have reduced the preservice clinical staff time to zero from the current input of 8 minutes. The intraservice time has also been reduced from 36 minutes to 27 minutes. The panel also eliminated a number of the supplies currently attributed to this servce as they were felt to not be necessary.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here: The expert panel agreed that using the key reference service, 20526, as a reference code for comparison would provide a helpful reference point for practice expense review. The refence code describes a very similar procedure with identical intraservice clinical staff time.

3. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: N/A

4. Please provide rationale for the minutes you are recommending for clinical activities that do not have PE Subcommittee standards: The expert panel is recommending 5 minutes for CA018 assist physician or other qualified healthcare professional – directly related to physician work time (100% of physician intra-service time). The clinical staff assists the physician or qualified health care professional during the entirety of the injection in order to ensure the patient remains in the proper position and that the physician or qualified health care professional has access to necessary supplies. The expert panel is recommending 3 minutes for CA023 monitor patient following procedure/service, no multitasking. The patient must be closely monitored in the minutes immediately following the procedure to ensure the patient is not experiencing any abnormal responses to the injection.

5. If you are requesting an increase over the current inputs in clinical staff time, supplies or equipment you must provide compelling evidence: The expert panel is recommending an increase in the number of needles from 1 to 2. One needle of a larger gauge is needed to draw up medication. A second, smaller gauge needle is used for comfort to perform the injection. The expert panel recommends adding an exam light, EQ168 for the procedure. The injection site for this procedure is often obstructed by hair. A light ensures that the site is visable so the physician can appropriately place the needle for the injection.

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Spreadsheet Update Workgroup and listed in tab 2, please explain the difference here: N/A

7. Please describe in detail the clinical activities of your staff below:

Pre-Service Period Clinical Activities: (0 minutes)

There are no clinical activities performed by staff during the pre-service period.

Service Period Clinical Activities: (27 total minutes)

Pre-Service (of Service Period): (13 minutes) Clinical staff greets the patient and provides the patient with gowning. The appropriate medical records in reference to the planned injection are reviewed. Pre-service education is provided Clinical staff reviews the patient's understanding of the risks and benefits of the procedure, then obtains and documents patient consent. The patient's vital signs are taken, including temperature, blood pressure and pulse to ensure that the patient is in appropriate condition to receive the injection. The room is prepared and the appropriate injection equipment (sterile trays, needles and medications) is obtained.

Intra-Service (of Service Period): (5 minutes) The clinical staff is present for the entire procedure, assisting the physician by providing sterile supplies as appropriate. Clinical staff also provides reassurance and distraction to the patient as necessary.

Post-Service (of Service Period): (9 minutes) After the procedure, clinical staff observes the patient to verify that they are comfortable and the injection site is checked a few minutes following the injection to monitor the patient for an allergic reaction or vasovagal event. Following completion of the procedure by the physician, the room is cleaned and the instructions given by the physician are reviewed again with the patient. The patient is escorted out of the office. Relevant forms are completed and replacement supplies are ordered.

Post-Service Period Clinical Activities: (3 minutes) Although this code is a zero-day global service, an average of one phone call is received specific to the injection. The clinical staff answers this call and addresses questions.

8. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:* The clinical staff helps to ensure that the patient's positioning remains consistent. The clinical staff also makes certain that all necessary supplies, including injectate and gauze are readily available to the physician or other qualified healthcare professional to ensure that the service can be provided without interruption.

9. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
N/A

10. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities:
N/A

11. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
N/A

12. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A

13. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here:
N/A

14. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:
N/A

15. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here:

Rows 24, 54 and 94 of the PE spreadsheet reflect the current RUC database PE time for code 64405. This PE does not coincide with a RUC review, therefore detailed information about minutes attributed to specific tasks was not available. Please note that line 54 reflects the current PE minutes for the entire service period including pre, intra and post service (of service period).

16. If there is any other item on your spreadsheet that needs further explanation please include here:
N/A

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**				**REFERENCE CODE**		**CURRENT**		**RECOMMENDED**	
2		***Please see brief summaries of the**			**CPT Code # 20526**		**CPT Code # 64405**		**CPT Code # 64405**	
3		***RUC Collaboration Website***			Injection, therapeutic (eg local anesthetic, corticosteroid), carpal tunnel		Injection, anesthetic agent; greater occiptal nerve		Injection, anesthetic agent; greater occipital nerve	
4	**Clinical Activity Code**	**Meeting Date: April 2017 Tab: 17 Specialty: AAN, AAPM, AAPM&R, ASA**	**Clinical Staff Type Code**	**Clinical Staff Type**						
5		**LOCATION**			**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**								
7		**TOTAL CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**29.0**	**0.0**	**47.0**	**17.0**	**18.0**	**0.0**
8		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**0.0**	**0.0**	**8.0**	**14.0**	**0.0**	**0.0**
9		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**26.0**	**0.0**	**36.0**	**0.0**	**18.0**	**0.0**
10		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**L037D**	RN/LPN/MTA	**3.0**	**0.0**	**3.0**	**3.0**	**0.0**	**0.0**
11		**PRE-SERVICE PERIOD**								
12		**Start: Following visit when decision for surgery or procedure made**								
13	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA				3		
14	CA002	Coordinate pre-surgery services (including test	L037D	RN/LPN/MTA						
15	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA				3		
16	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA			5	5		
17	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA			3	3		
18	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA						
19	CA007	Review patient clinical extant information and	L037D	RN/LPN/MTA						
20	CA008	Perform regulatory mandated quality assurance	L037D	RN/LPN/MTA						
26		**End: When patient enters office/facility for surgery/procedure**								
27		**SERVICE PERIOD**								
28		**Start: When patient enters office/facility for surgery/procedure:**								
29		**Pre-Service (of service period)**								
30	CA009	Greet patient, provide gowning, ensure appropriate	L037D	RN/LPN/MTA	2		3			
31	CA010	Obtain vital signs	L037D	RN/LPN/MTA			3			
32	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	3				3	
33	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA						
34	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	5		3		2	
35	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA						
36	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA						
37	CA016	Prepare, set-up and start IV, initial positioning and	L037D	RN/LPN/MTA	2		2		2	
38	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA						
45		**Intra-service (of service period)**								
46	CA018	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA	5		6		5	
47	CA019	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA						
48	CA020	Assist physician or other qualified healthcare	L037D	RN/LPN/MTA						
49	CA021	Perform procedure/service---NOT directly related to	L037D	RN/LPN/MTA						
55		**Post-Service (of service period)**								
56	CA022	Monitor patient following procedure/service,	L037D	RN/LPN/MTA	3		15			
57	CA023	Monitor patient following procedure/service, no	L037D	RN/LPN/MTA					3	
58	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	3		3			
59	CA025	Clean scope	L037D	RN/LPN/MTA						
60	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA						
61	CA027	Complete post-procedure diagnostic forms, lab and x-	L037D	RN/LPN/MTA						
62	CA028	Review/read post-procedure x-ray, lab and pathology	L037D	RN/LPN/MTA						
63	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA			1		1	
64	CA030	Technologist QC's images in PACS, checking for all	L037D	RN/LPN/MTA						
65	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA						
66	CA032	Scan exam documents into PACS. Complete exam in	L037D	RN/LPN/MTA						
67	CA033	Perform regulatory mandated quality assurance	L037D	RN/LPN/MTA						
68	CA034	Document procedure (nonPACS) (e.g. mandated	L037D	RN/LPN/MTA						
69	CA035	Review home care instructions, coordinate	L037D	RN/LPN/MTA	3				2	
70	CA036	Discharge day management	L037D	RN/LPN/MTA	**n/a**		**n/a**		**n/a**	
77		**End: Patient leaves office**								
78		**POST-SERVICE PERIOD**								
79		**Start: Patient leaves office/facility**								
80	CA037	Conduct patient communications	L037D	RN/LPN/MTA	3		3	3		
81	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA						
82		***Office visits: List Number and Level of Office Visits***	**MINUTES**		**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
83		99211 16 minutes	16							
84		99212 27 minutes	27							
85		99213 36 minutes	36							
86		99214 53 minutes	53							
87		99215 63 minutes	63							
88	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
95		**End: with last office visit before end of global**								
96	**Medical**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
97	SA048	pack, minimum multi-specialty visit	1.143	pack			1			
98	SB011	drape, sterile, fenestrated 16in x 29in	0.557	item	1		1			
99	SB024	gloves, sterile	0.84	pair	1		2		1	
100	SB028	gown, surgical, sterile	4.671	item			1			
101	SB044	underpad 2ft x 3ft (Chux)	0.23	item			2			
102	SG055	gauze, sterile 4in x 4in	0.159	item	1		2		1	
103	SC029	needle, 18-27g	0.089	item	2		1		2	
104	SC055	syringe 3ml	0.096	item			1			
105	SC057	syringe 5-6ml	0.15	item			1			
106	SC051	syringe 10-12ml	0.184	item	1		1		1	
107	SG009	applicator, sponge-tipped	0.139	item			1		1	
108	SH021	bupivacaine 0.25% inj (Marcaine)	0.254	ml			5		5	
109	SH047	lidocaine 1%-2% inj (Xylocaine)	0.035	ml	2		2			
110	SJ041	povidone soln (Betadine)	0.008	ml	10		10		10	
111		*Other supply item: please include the name of the*								
112	**Equipment**	**EQUIPMENT**	**PRICE**	**EQUIPMENT**						
113	EF023	table, exam	1338.17	Non-highly			36		18	
114	EQ168	light, exam	1630.12	Non-highly					0	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2019

Genicular Injection and RFA – Tab 10

In May 2018, the CPT Editorial Panel approved the addition of two codes to report injection of anesthetic and destruction of genicular nerves by neurolytic agent. In October 2018, the RUC thoroughly discussed the issues surrounding the survey of this family of services. The RUC supported the specialty societies' request for CPT codes 64454, 64640, and 64624 to be resurveyed and presented at the January 2019 RUC meeting based on their concern that many survey respondents appeared to be confused about the number of nerve branch injections involved with these three codes. The RUC recommended resurveying these services for January 2019.

Compelling Evidence
The specialty societies presented compelling evidence for this family of codes based on a change in physician work due to changes in technique and change in patient population. CPT codes 64450 and 64640 both describe a single injection/ablation. In contrast, CPT code 64454 involves blocks for three different nerve branches (superomedial, inferomedial, and superolateral genicular nerve branches) at three locations (adjacent to the periosteum on the medial aspect of the tibia, and at both the medial and lateral aspects of the femur) in order to achieve analgesia for the respective knee. CPT code 64624 involves ablation for three different nerve branches (superomedial, inferomedial, and superolateral genicular nerve branches) at three locations (adjacent to the periosteum on the medial aspect of the tibia, and at both the medial and lateral aspects of the femur) in order to achieve analgesia for the respective knee. The two new codes include imaging guidance. Imaging, which is typical and necessary to perform these genicular nerve branch procedures, is bundled into codes 64454 and 64624.

Regarding the change in patient population, when CPT code 64640 was surveyed in 2011, the typical patient had a history of neuritis of the medial calcaneal nerve. The current top diagnosis codes for code 64640 are not related to the calcaneal nerve but to other inflammatory spondylopathies; mononeuropathies of lower limb; other joint disorders; spondylosis; and other unspecified dorsopathies. The change in patient population is a result of coding changes between the 2011 and 2019 surveys where the typical podiatric patient is now reported with a different code. The RUC concluded that the change in the typical patient now made the typical service described by code 64640 more intense and complex. Currently, clinicians are reporting services described by code 64624 with code 64640. Therefore, the typical patient has changed for code 64640. The RUC approved compelling evidence for the family based on change in patient population and a change in technique.

64454 ***Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed***
The RUC reviewed the survey results from 69 physicians and determined that the survey 25th percentile work RVU of 1.52 accurately reflects the physician work necessary for this service for pain management of chronic knee osteoarthritis. The RUC recommends 17 minutes pre-service evaluation time, 1 minute pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 18 minutes intra-service time and 10 minutes immediate post-service time.

The RUC compared CPT code 64454 to the top key reference code 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (work RVU = 1.52 and 15 minutes intra-service time) and noted the solid comparison with same amount of physician work and similar intra-service times. Over 3/4 of survey respondents indicated that the surveyed code was identical in overall intensity/complexity to the key reference code. For additional support, the RUC referenced CPT code 43197 *Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (work RVU = 1.52 and 15 minutes intra-service time) and noted similarly that this code has the same amount of physician work and nearly identical intra-service time. Further, the RUC compared the survey code to another injection code 62284 *Injection procedure for myelography and/or computed tomography, lumbar* (work RVU= 1.54 and 15 minutes intra-service time) and noted that this code involves similar physician work and intra-service time.

The RUC concluded that CPT code 64454 should be valued at the 25th percentile work RVU of 1.52 as supported by the survey and top key reference service and which is also consistent with the recommendation for the sacroiliac joint. **The RUC recommends a work RVU of 1.52 for CPT code 64454.**

64640 *Destruction by neurolytic agent; other peripheral nerve or branch*
The RUC reviewed the survey results from 60 physicians and determined that the survey 25th percentile work RVU of 1.98 accurately reflects the physician work necessary for this service which now involves a more complex patient. The RUC questioned the intra-service time which increased from 5 minutes to 20 minutes, and ultimately supported the survey results. It noted that since both the October 2018 and the January 2019 survey resulted in a median intra-service time of 20 minutes, this increase in time was appropriate and reflected the change in the intensity and complexity of the typical patient from the 2011 RUC survey to the current 2019 RUC survey. Furthermore, the increase in intra-service time supports an increase in work RVU. The RUC recommends 13 minutes pre-service evaluation time, 1 minute pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 20 minutes intra-service time and 9 minutes immediate post-service time, and 1-99212 office visit. While the survey data resulted in 1-99213 office visit, the RUC agreed that a 99212 was more appropriate and better reflected current practice.

The RUC compared CPT code 64640 to the top key reference code 64633 *Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint* (work RVU = 3.84 and 30 minutes intra-service time) and noted that it was appropriate for the reference code to be valued higher than the surveyed code because code 64633 includes imaging guidance while code 64640 does not. Survey respondents indicated that the survey code was either the same or of greater intensity than the reference code. The RUC also compared the survey code to the second key reference service code 64632 (*Destruction by neurolytic agent; plantar common digital nerve*) (work RVU = 1.23 and 5 minutes intra-service time) and noted that the survey code should be valued higher than code 64632 given the differences in intra-service times. CPT code 64632 has an intra time of 5 minutes versus 20 minutes for the survey code. The typical patient for code 64632 is a patient receiving an injection in the sole of their foot while the typical patient for code 64640 is a patient with severe pain involving the left chest wall. Survey respondents indicated that the survey code was either the same or of greater intensity than the reference code.

For additional support, the RUC referenced CPT code 17272 *Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm*) (work RVU = 1.82 and 22 minutes intra-service time) and CPT code 12031 *Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 2.5 cm or less*) (work RVU = 2.00 and 20 minutes intra-service time) and agreed that these codes appropriately bracket the survey code. The RUC

concluded that CPT code 64640 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.98 for CPT code 64640.**

64624 ***Destruction by neurolytic agent genicular nerve branches including imaging guidance, when performed***
The RUC reviewed the survey results from 69 physicians and recommends a work RVU of 2.62 which is supported by a direct work RVU crosswalk to MPC code 11642 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm* (work RVU = 2.62, 25 minutes intra-service time and 68 minutes total time) and falls slightly above the survey 25th percentile. CPT code 64624 describes the destruction of three different nerve branches at three locations in order to *provide* analgesia for the respective knee. The crosswalked code describes excision of a malignant lesion. The physician work involved in the survey code is slightly more intense in that the destruction of three different nerve branches, if performed incorrectly would have the potential to produce irreversible tissue damage to other motor or sensory nerves in the vicinity of the knee. The RUC determined that the crosswalk is reasonable and appropriate in terms of times, intensity and physician work.

The RUC recommends 17 minutes pre-service evaluation time, 1 minute pre-service positioning time, 5 minutes pre-service scrub/dress/wait time, 25 minutes intra-service time and 10 minutes immediate post-service time, and 1-99212 office visit. The intra-service time of 25 minutes represents an increase of 5 minutes or 25 percent from the October 2018 survey. The RUC concluded that there was better understanding by survey respondents that the code described multiple injections in the more recent survey versus the October 2018 survey. While both the crosswalk code and the survey data had a 1-99213 office visit, the RUC agreed that a 99212 was more appropriate and better reflected current practice.

To further support a work RVU of 2.62, the RUC referenced CPT code 10061 *Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple* (work RVU = 2.45, 25 minutes intra-service time) and noted that the intra-service times are identical but the reference code has a lower intensity than both the crosswalk and survey code, and the survey code is therefore appropriately valued higher than the reference code. The RUC agrees with the direct crosswalk recommendation of 2.62 work RVUs and believes that it appropriately ranks this procedure within the family. **The RUC recommends a work RVU of 2.62 for CPT code 64624.**

Practice Expense
The Practice Expense Subcommittee accepted compelling evidence and made substantial changes to the equipment and the equipment minutes, corrected intra-service times, added minutes to code 64450 for CA006, and made changes to supplies. PE Subcommittee members questioned including both equipment items: mobile c-ARM room (EL018) at a purchase price of $151,200 and fluoroscopy table (EF024) at a purchase price of $227,650 to perform one service with fluoroscopy. The PE Subcommittee agreed that the C-arm does not include a table, so maintained the room, mobile c-ARM (EL018), removed the table, fluoroscopy (EF024) and added in the table, power (EF031) as a proxy for fluoroscopy table until invoices can be obtained to reprice the fluoroscopy table, which PE Subcommittee members agreed should have a purchase price between $10,000 and $15,000. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Affirmation of RUC Recommendations
The RUC affirmed the recent RUC recommendation for CPT code *64450 Injection, anesthetic agent; other peripheral nerve or branch* (work RVU= 0.75, 7 minutes pre-service evaluation time, 1 minute pre-service positioning time, 1 minute pre-service scrub/dress/wait time, 5 minutes intra-service time and 5 minutes immediate post-service time). The relativity within the family remains correct. **The RUC affirms the work RVU of 0.75 for CPT code 64450.**

New Technology
The RUC recommends that this family of codes be placed on the New Technology/New Services list and be re-reviewed by the RUC in three years in order to verify utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Nervous System **Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System** **Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic** *(For destruction by neurolytic agent or chemodenervation, see 62280-62282, 64600-64681)* *(For epidural or subarachnoid injection, see 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327)* *(64479-64487, 64490-64495 are unilateral procedures. For bilateral procedures, use modifier 50)* **Somatic Nerves** *64400 Injection, anesthetic agent; trigeminal nerve, any division or branch*				
(f)64450	H18	Injection, anesthetic agent; other peripheral nerve or branch	000	0.75 (Affirmed October 2018 RUC recommendation)
●64454	G1	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed (Do not report 64454 in conjunction with 64624) (64454 requires injecting all of the following genicular nerve branches: superolateral, superomedial, and inferomedial. If all three of these genicular nerve branches are not injected, report 64454 with modifier 52)	000	1.52

Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency), Chemodenervation

Codes 64600-64681 include the injection of other therapeutic agents (eg, corticosteroids). Do not report diagnostic/therapeutic injections separately. Do not report a code labeled as destruction when using therapies that are not destructive of the target nerve (eg, pulsed radiofrequency), use 64999. For codes labeled as chemodenervation, the supply of the chemodenervation agent is reported separately.

(For chemodenervation of internal anal sphincter, use 46505)

(For chemodenervation of the bladder, use 52287)

(For chemodenervation for strabismus involving the extraocular muscles, use 67345)

(For chemodenervation guided by needle electromyography or muscle electrical stimulation, see 95873, 95874)

Somatic Nerves

64600 Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch

(f)64640	G2	Destruction by neurolytic agent; other peripheral nerve or branch	010	1.98
●64624	G3	Destruction by neurolytic agent genicular nerve branches including imaging guidance, when performed (64624 requires the destruction of each of the following genicular nerve branches: superolateral, superomedial, and inferomedial. If a neurolytic agent for the purposes of destruction is not applied to all of these nerve branches, report 64624 with modifier 52) (Do not report 64624 in conjunction with 64454)	010	2.62

American Society of Anesthesiologists™

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December 19, 2018

Peter K. Smith, MD, Chair
AMA/RVS Update Committee (RUC)
American Medical Association
330 N. Wabash Ave.
Chicago, IL 60611

Re: Code 64450, Injection, anesthetic agent; other peripheral nerve or branch

Dear Dr. Smith:

At the October 2018 RUC meeting the RUC reviewed the survey results for code 64450 (*Injection, anesthetic agent; other peripheral nerve or branch*) from 88 physicians and agreed on the following physician time components: 7 minutes of pre-service evaluation, 1 minute of pre-service positioning, 1 minute of pre-service scrub/dress/wait, 5 minutes of intra-service time and 5 minutes of immediate post-service time. The RUC recommended a work RVU of 0.75 for this code.

At this meeting the RUC also facilitated a tab composed of CPT codes 64XX0 (*Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed*), 64640 (*Destruction by neurolytic agent; other peripheral nerve or branch*), and 64XX1 (*Destruction by neurolytic agent genicular nerve branches (including imaging guidance, when performed*)). The RUC facilitated this tab and thoroughly discussed the issues surrounding the survey of this family of services. The specialties noted their concern that many survey respondents appeared to be confused about the number of nerve branch injections involved with these three codes. The RUC supported the specialty societies' request for CPT codes 64XX0, 64640, and 64XX1 to be resurveyed and recommended resurveying these services for January 2019 RUC meeting.

Since the services described by code 64XX0 are currently reported by code 64450, the RUC requested the specialties to also survey code 64450 for the January 2019 RUC meeting. There has been no change in the physician work for this code since the October 2018 meeting and the issues related to the resurvey of 644X0, 64640 and 64XX1 do not apply to this code. We do not believe a re-survey of code 64450 is necessary. The joint societies therefore recommend that the recently recommended RUC value and inputs for code 64450 (0.75 work RVU) are reaffirmed at the January 2019 RUC meeting.

We look forward to presenting our recommendations for codes 64XX0, 64640 and 64XX1 at the upcoming RUC meeting. Please contact Sharon Merrick, M.S. CCS-P, staff for the American Society of Anesthesiologists at 202-289-2222 or via email at s.merrick@asahq.org. Thank you for your consideration of this request.

Sincerely,

Eduardo Fraifeld, MD
Gregory Polston, MD
American Academy of Pain Medicine (AAPM)

Matthew Grierson, MD
American Academy of Physical Medicine and Rehabilitation (AAPM&R)

Richard Rosenquist, MD
American Society of Anesthesiologists (ASA)

Vikram Patel, MD
American Society of Interventional Pain Physicians (ASIPP)

Wesley Ibazebo, MD
Spine Intervention Society (SIS)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code: 64454 Tracking Number Original Specialty Recommended RVU: **1.90**
Presented Recommended RVU: **1.52**
Global Period: 000 Current Work RVU: RUC Recommended RVU: **1.52**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78-year-old female has a 5-year history of persistent right knee pain that is interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a trial of genicular nerve blocks is scheduled to relieve her pain and improve her function.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The proposed site of the procedure is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injection is prepared. The skin is cleansed with an antiseptic solution, sterile drapes are applied. The skin around the planned entry point is injected with local anesthetic. Perform a universal timeout procedure.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. The procedure is performed under fluoroscopic guidance. The superolateral, superomedial and inferomedial genicular nerves are targeted adjacent to the periosteum on the medial aspect of the tibia, and at both the medial and lateral aspects of the femur at the junctions of the shaft and the epicondyle. Under imaging guidance, the target areas are approached by introducing a spinal needle from either an anteroposterior or lateral entry point with the final position residing adjacent to the bone. After negative aspiration, local anesthetic is deposited at each of the sites. The needle and stylet are removed.

Description of Post-Service Work: The sites are covered with a sterile occlusive dressing. The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2019
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Scott Horn, DO (SIS); Wesley Ibazebo, MD (SIS); Marc Leib, MD (ASA); Vikram Patel, MD (ASIPP); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA)
Specialty Society(ies):	American Academy of Pain Medicine (AAPM); American Academy of Physical Medicine and Rehabilitation (AAPM&R); American Society of Anesthesiologists (ASA); American Society of Interventional Pain Physicians (ASIPP); Spine Intervention Society (SIS)
CPT Code:	64454

Sample Size:	7773	**Resp N:**	69	**Response:**	0.8 %
Description of Sample:	random				

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**15.00**	30.00	500.00
Survey RVW:	1.00	1.52	**1.90**	2.20	10.00
Pre-Service Evaluation Time:			**17.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	13.00	**18.00**	22.00	55.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	64454	**Recommended Physician Work RVU: 1.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**17.00**	**17.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**18.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64493	000	1.52	**RUC Time**

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64483	000	1.90	**RUC Time**

CPT Descriptor Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64479	000	2.29	**RUC Time**	45,349

CPT Descriptor 1 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20611	000	1.10	**RUC Time**	995,488

CPT Descriptor 2 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 35 **% of respondents:** 50.7 **%**

Number of respondents who choose 2nd Key Reference Code: 11 **% of respondents:** 15.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 64454	Top Key Reference CPT Code: 64493	2nd Key Reference CPT Code: 64483
Median Pre-Service Time	23.00	17.00	24.00
Median Intra-Service Time	18.00	15.00	15.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**51.00**	**42.00**	**49.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	9%	77%	14%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	80%	11%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	17%	74%	9%

Physical effort required	9%	66%	26%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	26%	69%	6%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	18%	36%	36%	9%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	18%	45%	36%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	9%	55%	36%
Physical effort required	0%	45%	54%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	27%	36%	36%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT code 64454 (*Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed*) is a 0-day global code which was surveyed for the January 2019 RUC meeting by the American Society of Anesthesiologists (ASA), the American Academy of Pain Medicine (AAPM), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Society of Interventional Pain Physicians (ASIPP) and the Spine Intervention Society (SIS).

Code 64454 involves blocks for 3 different nerve branches (superomedial, inferomedial, and superolateral genicular nerve branches) at three locations (adjacent to the periosteum on the medial aspect of the tibia, and at both the medial and lateral aspects of the femur) in order to achieve analgesia for the respective knee. It includes image guidance, when performed. The code was approved at the May 2018 CPT Editorial Panel meeting.

This code was previously surveyed for the October 2018 meeting. At the October 2018 RUC meeting, the specialties noted their concern that many survey respondents appeared to be confused about the number of nerve branch injections involved with two codes in the tab: 64454 and 64624. The RUC recommended resurveying the entire tab for the January 2019 RUC meeting. Unlike the October 2018 survey, the January 2019 survey included the code's parenthetical language which indicated that code 64454 involved blocks of three different nerve branches.

A total of 69 responses were received from a random sample of 7,773 clinicians (0.8% response rate). The survey conducted was robust and captured a wide variety of specialists who regularly perform the procedure and who showed recent experience with the procedure. The societies convened an expert panel to review the survey data. ***The societies are recommending the survey median of 1.90 wRVUs and a time of pre (7/1/1), intra (18 min) and post (10 min).*** This results in an IWPUT of: 0.083.

Survey Data: wRVU and Time

The expert panel reviewed the survey data for the January 2019 RUC meeting.

64454 Highlights from January 2018 Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.52	1.90	2.20
Pre		17/5/5	
Intra	13	18	22
Post		10	

97 percent of the survey respondents found the vignette to be typical.

The expert panel also reviewed the survey data from the October 2018 survey.

64454 Highlights from October 2018 Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.40	1.60	2.00
Pre		24/5/5	
Intra	10	15	20
Post		9	

Survey Time Data

The expert panel reviewed the survey data in developing their time recommendations.

- Pre-time: The expert panel is recommending an adjusted Non-Facility Pre Time Package 5 (adjusted) of 7/1/1. This pre-service package is consistent with other recently and/or currently reviewed nerve treatment by injection codes such as the family of somatic nerves reviewed at the October 2018 RUC meeting.
- Intra-time: The expert panel is recommending the survey median intra time of 18 minutes. This represents an increase of 3 minutes or 20 percent from the October 2018 survey which had a median intra time of 15 minutes. The expert panel concluded that there was better understanding by survey respondents that the code described multiple injections in the more recent survey versus the October 2018 survey.
- Post time: The expert panel is recommending the survey median post time of 10 minutes. They felt this was also in-line with the post time of other recently and/or currently reviewed nerve treatment by injection codes such as the family of somatic nerves reviewed at the October 2018 RUC meeting.

wRVU Recommendation

After a robust discussion, the specialties are recommending the survey median of 1.90 wRVUs and physician time of pre (7/1/1), intra (18) and post (10). The expert panel considered a number of factors in determining the appropriateness of the recommendation.

- Reference codes: The top key reference code selected by survey respondents was code **64493** (*Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level*) valued at 1.52 wRVUs and the second key reference code was code **64483** (*Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level*) valued at 1.90 wRVUs. The expert panel concluded that the recommended wRVU was supported by the reference codes selected by survey respondents.
    - 64493: The expert panel agreed that it was appropriate for the surveyed code 64454 to be valued more than the top reference code 64493 which was selected by 35 survey respondents. The survey respondents indicated that the surveyed code was either identical or of greater intensity than the reference code. The expert panel also noted that the reference code had intra time of three minutes less than the surveyed code
    - 64483: The expert panel agreed that is was appropriate for the surveyed code to be valued the same as the 2nd top key reference code 64483 which was selected by 11 survey respondents. The typical patient for 64483 presents with recurrent leg pain and the typical patient for 64454 presents with persistent knee pain. They noted that survey respondents indicated that the surveyed code was either the same or of greater intensity than the reference code.

- Building block comparison: The expert panel also considered the appropriateness of the recommendation by considering a building block approach. Code 64454 describes 3 injections which are described by code 64450 (*Injection, anesthetic agent; other peripheral nerve or branch*) valued at 0.75 wRVUs and imaging which is described by 77002 (*Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure*)) which is valued at 0.54 wRVUs. Applying the multi-procedure reduction policy all of these services add up to 2.04 wRVUs which is more than the recommended value of 1.90 wRVUs. The expert panel concluded that this provided further evidence of the appropriateness of the recommendation.
    - 0.75 + (.5 (0.75 + 0.75)) + 0.54 = 2.04 wRVUs

- Other comparison codes: The expert panel also identified comparison code reference codes which support the recommended value of 1.90 wRVUs.

Code #	Long Descriptor	Global	Work RVU	IWPUT	Intra Time
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level	000	1.82	0.0858	15
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)	000	1.90	0.0866	15
64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed	**000**	**1.90**	**0.083**	**18**
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)	000	1.95	0.0900	15
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level	000	2.29	0.1076	15

In summary, for code 64454 the societies are recommending 1.90 wRVUs and time of pre (7/1/1), intra (18 min) and post (10 min).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Code 64450

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Pain Management How often? Commonly

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 87616
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate.

Specialty Anesthesiology Frequency 29000 Percentage 33.09 %

Specialty Pain Management Frequency 16000 Percentage 18.26 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 35,046 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology Frequency 12228 Percentage 34.89 %

Specialty Pain Management Frequency 10556 Percentage 30.12 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number N/A

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64450

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64640 Tracking Number Original Specialty Recommended RVU: **1.98**
Presented Recommended RVU: **1.98**
Global Period: 010 Current Work RVU: **1.23** RUC Recommended RVU: **1.98**

CPT Descriptor: Destruction by neurolytic agent; other peripheral nerve or branch

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 60-year-old female presents with severe pain involving the left chest wall due to metastatic lung cancer with invasion of the chest wall. She is nearing the end of life and has failed multiple interventions and management. A diagnostic intercostal nerve block provided short term relief. The decision is made to perform a percutaneous neurolytic procedure of the intercostal nerve in order to obtain more prolonged relief.

Percentage of Survey Respondents who found Vignette to be Typical: 88%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 28% , In the ASC 33%, In the office 38%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Discuss and review the treatment options with the patient. Review X-rays and appropriate diagnostic studies. Review the procedure with the patient and any family members as appropriate, discuss possible complications and obtain patient consent. Apply monitors, obtain and review vital signs, examine proposed injection site and apply a grounding pad. Don hair cover, mask and sterile gloves. Prepare the injection by setting up the sterile tray with the appropriate supplies and drawing up local anesthetics. Place the patient in a prone position, cleanse the site of the proposed injection and place a sterile barrier on the patient. Inject local anesthetic to numb the skin and subcutaneous issues. Perform a universal time-out procedure.

Description of Intra-Service Work: Palpate the ribs to identify the affected intercostal nerve level. Palpate the inferior border of the rib and mark the proposed injection site. Insert a radiofrequency needle and direct it until it contacts the inferior border of the rib. Pull the radiofrequency needle back slightly and advance the needle under the inferior border of the rib. Aspirate carefully prior to injection to assure the absence of blood or air prior to the injection. Inject local anesthetic to numb the intercostal nerve prior to performing the radiofrequency ablation. Radiofrequency ablation is performed. The target tissue should reach 80 degrees for 90 seconds. Remove the needle.

Description of Post-Service Work: Apply a bandage. Obtain and review immediate post injection vital signs. Monitor the patient for any potential complications related to the injection. Instruct the patient and/or care giver on appropriate activities and home care. Discuss future management of the condition. Dictate notes for the patient's medical record. Dictate a procedure note and a letter to the patient's PCP/Referring Physician and/or insurance company. At the follow-up office visit, examine the patient and discuss treatment success or adverse reactions that may have occurred after the procedure. Revise the treatment plan(s) as necessary.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2019					
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Scott Horn, DO (SIS); Wesley Ibazebo, MD (SIS); Marc Leib, MD (ASA); Vikram Patel, MD (ASIPP); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA)					
Specialty Society(ies):	American Academy of Pain Medicine (AAPM); American Academy of Physical Medicine and Rehabilitation (AAPM&R); American Society of Anesthesiologists (ASA); American Society of Interventional Pain Physicians (ASIPP); Spine Intervention Society (SIS)					
CPT Code:	64640					
Sample Size:	7773	**Resp N:**	60	**Response:** 0.7 %		
Description of Sample:	random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**10.00**	25.00	500.00	
Survey RVW:	1.00	1.98	**3.10**	3.84	10.00	
Pre-Service Evaluation Time:			**18.00**			
Pre-Service Positioning Time:			**5.00**			
Pre-Service Scrub, Dress, Wait Time:			**5.00**			
Intra-Service Time:	1.00	15.00	**20.00**	30.00	55.00	
Immediate Post Service-Time:	**8.50**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64640	**Recommended Physician Work RVU: 1.98**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**9.00**	**18.00**	**-9.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64633	010	3.84	**RUC Time**

CPT Descriptor Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64632	010	1.23	**RUC Time**

CPT Descriptor Destruction by neurolytic agent; plantar common digital nerve

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11403	010	1.84	**RUC Time**	47,796

CPT Descriptor 1 Excision, benign lesion including margins, except skin tab (unless listed elsewhere), trunk, arms or legs; excised diameter 2.1 to 3.0 cm

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
11601	010	2.07	**RUC Time**	26,641

CPT Descriptor 2 Excision, malignant lesion including margins, trunk, arms, or legs; excised diameter 0.6 to 1.0 cm

Other Reference CPT Code	Global	Work RVU	Time Source
67840	010	2.09	**RUC Time**

CPT Descriptor Excision of lesion of eyelid (except chalazion) without closure or with simple direct closure

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 55 **% of respondents:** 91.6 **%**

Number of respondents who choose 2nd Key Reference Code: 3 **% of respondents:** 5.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 64640	Top Key Reference CPT Code: 64633	2nd Key Reference CPT Code: **64632**
Median Pre-Service Time	19.00	29.00	10.00
Median Intra-Service Time	20.00	30.00	5.00
Median Immediate Post-service Time	9.00	15.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	19.00	0.00
Median Office Visit Time	16.0	23.00	16.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**64.00**	**116.00**	**36.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	2%	70%	23%	5%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	2%	74%	23%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	5%	63%	33%
Physical effort required	7%	72%	21%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	16%	51%	34%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	50%	33%	17%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	67%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	50%	50%
Physical effort required	0%	67%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

CPT code 64640 (*Destruction by neurolytic agent; other peripheral nerve or branch*) is a 10-day global code which was surveyed for the January 2019 RUC meeting by the American Society of Anesthesiologists (ASA), the American Academy of Pain Medicine (AAPM), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Society of Interventional Pain Physicians (ASIPP) and the Spine Intervention Society (SIS). This code was previously surveyed for the October 2018 meeting and prior to that was surveyed in 2011.

At the October 2018 RUC meeting, the specialties noted their concern that many survey respondents appeared to be confused about the number of nerve branch injections involved with two of the other codes in the tab: 64454 and 64624. The RUC recommended resurveying the entire tab for the January 2019 RUC meeting.

A total of 60 responses were received from a random sample of 7,773 clinicians (0.7% response rate). The survey conducted was robust and captured a wide variety of specialists who regularly perform the procedure and who showed a significant amount of recent experience with the procedure. The societies convened an expert panel to review the survey data. ***The societies are recommending the survey 25th percentile of 1.98 wRVUs and a time of pre (13/1/5), intra (20 min) and post (8.5 min) and (1) 99212 office visit.*** This results in an IWPUT of: 0.048.

Survey Data: wRVU and Time

The expert panel reviewed the survey data for the January 2019 RUC meeting.

64640 Highlights from January 2018 Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.98	3.10	3.84
Pre		18/5/5	
Intra	15	20	30
Post		8.50	

The expert panel also reviewed the survey data from the October 2018 survey.

64640 Highlights from October 2018 Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	1.88	2.35	3.73
Pre		24.5/6/5	
Intra	15	20	29.25
Post		10	

Survey Time Data

The expert panel reviewed the survey data in developing their time recommendations.

- Pre-time: The expert panel is recommending the adjusted Facility Pre Time Package 1 (adjusted) of 13/1/5. This pre-service package is consistent with other recently and/or currently reviewed nerve treatment by injection codes such as the family of somatic nerves reviewed at the October 2018 RUC meeting.
- Intra-time: The expert panel is recommending the survey median intra time of 20 minutes. This represents an increase from the current intra time of 5 minutes. The expert Panel noted that since both the October 2018 and the January 2019 survey resulted in a median intra time of 20 minutes, they were comfortable that this increase in time was appropriate and reflected the change in the intensity and complexity of the typical patient from the 2011 RUC survey to the current 2019 RUC survey.
- Post time: The expert panel is recommending the survey median post time of 8.5 minutes. They felt this was probably a little low but still in-line with the post time of other recently and/or currently reviewed nerve treatment by injection codes such as the family of Somatic nerves reviewed at the October 2018 RUC meeting.
- Office visit: The expert panel is recommending 1-99212 office visit. While the survey data resulted in 1-99213 office visit, the expert panel concluded that a 99212 was more appropriate and better reflected current practice.

Recommendation

The specialties are recommending the 25th percentile of 1.98 wRVUs and physician time of pre (13/1/5), intra 20 and post (8.5) and 1-99212 office visit. Code 64640 is currently valued at 1.23 wRVUs with physician time of pre (10), intra (5) and post (5) and 1-99212 office visit.

- wRVU: The specialties recognize that their recommendation represents an increase of the current value from 1.23 wRVUs to 1.98 wRVUs. The expert panel concluded that this increase was appropriate because of the change in the typical patient which now made the typical service described by code 64640 more intense and complex.
    - Change in typical patient: The current vignette for the typical patient is a 50-year-old female who has a history of neuritis of the medial calcaneal nerve. This vignette was from the 2011 survey. For the January 2019 survey the typical patient is a 60-year-old female with severe pain involving the left chest wall due to metastatic lung cancer with invasion of the chest wall. The change in patient population is a result of coding changes in the intervening years where the typical podiatric patient is now reported with a different code. The new vignette is based on the current top diagnosis codes listed in the RUC database.
- Intra-service time: The expert panel also noted that the increase of intra-service time from 5 minutes to 20 minutes which likely reflected the change in the typical patient also provided additional justification for the increase in wRVUs. The recommended wRVU resulted in an IWPUT of 0.048 which seemed reasonable to the expert panel and aligns well with other similar codes.

Reference codes: The top key reference code selected by survey respondents was code **64633** (*Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint*) valued at 3.84 wRVUs and the second key reference code was code **64632** (*Destruction by neurolytic agent; plantar common digital nerve*) valued at 1.23 wRVUs. The expert panel concluded that the recommended wRVU was supported by the reference codes selected by survey respondents.

- 64633: The expert panel agreed that it was appropriate for 64633 to be valued more than the surveyed code 64640. Code 64633 included imaging guidance while 64640 did not. They noted that survey respondents indicated that the surveyed code was either the same or of greater intensity than the reference code.
- 64632: The expert panel agreed that is was appropriate for the surveyed code to be valued higher than code 64632. Code 64632 has an intra time of 5 minutes versus 20 minutes for the surveyed code. The typical patient for code 64632 is someone getting an injection in the sole of their foot while the typical patient for 64640 is someone with severe pain involving the left chest wall. They noted that survey respondents indicated that the surveyed code was either the same or of greater intensity than the reference code.

Other comparison codes: The expert panel also identified comparison code reference codes which support the recommended value of 1.98 wRVUs.

Code #	Long Descriptor	Global	Work RVU	IWPUT	Intra Time
11441	Excision, other benign lesion including margins, except skin tab (unless listed elsewhere) face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.6 to 1.0 cm	010	1.53	0.0357	20
17272	Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement) scalp, neck, hands, feet, genitalia; lesion diameter 1.1 to 2.0 cm	010	1.82	0.0480	22
64640	**Destruction by neurolytic agent; other peripheral nerve or branch**	**010**	**1.98**	**0.048**	**20**
12031	Repair, intermediate, wounds of scalp, axillae, trun and/or extremities (excluding hands and feet); 2.5 cm or less	010	2.00	0.0572	20
30802	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)	010	2.08	0.0576	20
10061	Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple	010	2.45	0.0392	25

In summary, the societies are recommending 1.98 wRVUs and time of pre (13/1/5), intra (20 min) and post (8.5 min) and (1) 99212 office visit.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Existing code 64640

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology How often? Commonly

Specialty Pain Management How often? Commonly

Specialty Interventional Pain Management How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 328852
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology Frequency 77050 Percentage 23.42 %

Specialty Pain Management Frequency 74485 Percentage 22.65 %

Specialty Interventional Pain Management Frequency 55313 Percentage 16.82 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 109,617 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology Frequency 25683 Percentage 23.42 %

Specialty Pain Management Frequency 24828 Percentage 22.64 %

Specialty Interventional Pain Management Frequency 18438 Percentage 16.82 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64640

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. N/A

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64624 Tracking Number Original Specialty Recommended RVU: **3.80**
Presented Recommended RVU: **3.29**
Global Period: 010 Current Work RVU: RUC Recommended RVU: **2.62**

CPT Descriptor: Destruction by neurolytic agent genicular nerve branches (including imaging guidance, when performed)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 78-year-old female has a 5-year history of persistent right knee pain that is interfering with her ability to complete activities of daily living. She has had poor control of her pain despite multiple medication trials and physical therapy. Due to her persistent, debilitating pain, a trial of genicular nerve blocks was conducted and found to temporarily relieve her pain and improve her function. She is now scheduled for genicular nerve radiofrequency lesioning to provide longer term sustained pain relief.

Percentage of Survey Respondents who found Vignette to be Typical: 99%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 29% , In the ASC 36%, In the office 35%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The proposed site of the procedure is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injection is prepared. The skin is cleansed with an antiseptic solution, sterile drapes are applied. The skin around the planned entry point is injected with local anesthetic. Perform a universal time-out procedure.

Description of Intra-Service Work: The appropriate skin and bony landmarks are identified. The procedure is performed under fluoroscopic guidance. The superolateral, superomedial and inferomedial genicular nerves are targeted adjacent to the periosteum on the medial aspect of the tibia, and at both the medial and lateral aspects of the femur at the junctions of the shaft and the epicondyle. Under imaging guidance, a radiofrequency cannula is guided from either an anteroposterior or lateral entry point with the final position residing adjacent to the bone. Motor stimulation is also performed to ensure the absence of adjacent motor fibers. After positive confirmation of sensory placement and negative motor testing, local anesthetic is administered adjacent to the nerve to mitigate pain associated with radiofrequency lesioning. Radiofrequency ablation is performed. The target tissue should reach 80 degrees for 90 seconds. The needle and stylet are removed,.

Description of Post-Service Work: The sites are covered with a sterile occlusive dressing. The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made. The patient is discharged after a period of monitoring and when there is independent ambulation. At the follow-up office visit, the patient is examined and treatment success or adverse reactions that may have occurred after the procedure are discussed. Revise the treatment plan(s) as necessary. Dictate notes for the patient's medical record.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2019				
Presenter(s):	Neal Cohen, MD (ASA); Eduardo Fraifeld, MD (AAPM); Matthew Grierson, MD (AAPM&R); Scott Horn, DO (SIS); Wesley Ibazebo, MD (SIS); Marc Leib, MD (ASA); Vikram Patel, MD (ASIPP); Gregory Polston, MD (AAPM); Richard Rosenquist, MD (ASA)				
Specialty Society(ies):	American Academy of Pain Medicine (AAPM); American Academy of Physical Medicine and Rehabilitation (AAPM&R); American Society of Anesthesiologists (ASA); American Society of Interventional Pain Physicians (ASIPP); Spine Intervention Society (SIS)				
CPT Code:	64624				
Sample Size:	7773	**Resp N:**	69	**Response:** 0.8 %	
Description of Sample:	random				

	Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate	0.00	4.00	**10.00**	20.00	500.00
Survey RVW:	1.00	2.50	**3.80**	4.00	10.00
Pre-Service Evaluation Time:			**20.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	1.00	16.00	**25.00**	36.00	90.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	64624	**Recommended Physician Work RVU: 2.62**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**17.00**	**17.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**25.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**10.00**	**18.00**	**-8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**16.00**	99211x **0.00** 12x **1.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64633	010	3.84	**RUC Time**

CPT Descriptor Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64632	010	1.23	**RUC Time**

CPT Descriptor Destruction by neurolytic agent; plantar common digital nerve

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64635	010	3.78	**RUC Time**	309,137

CPT Descriptor 1 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64561	010	5.44	**RUC Time**	14,924

CPT Descriptor 2 Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed

Other Reference CPT Code	Global	Work RVU	Time Source
36578	010	3.29	**RUC Time**

CPT Descriptor Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 43 **% of respondents:** 62.3 **%**

Number of respondents who choose 2nd Key Reference Code: 6 **% of respondents:** 8.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 64624	Top Key Reference CPT Code: 64633	2nd Key Reference CPT Code: 64632
Median Pre-Service Time	23.00	29.00	10.00
Median Intra-Service Time	25.00	30.00	5.00
Median Immediate Post-service Time	10.00	15.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	19.00	0.00
Median Office Visit Time	16.0	23.00	16.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**74.00**	**116.00**	**36.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	9%	60%	28%	2%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	73%	18%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	21%	61%	19%

Physical effort required	13%	57%	30%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	29%	53%	18%

2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	0%	100%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	100%	0%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	33%	0%	67%
Physical effort required	0%	0%	100%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	33%	33%	33%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Code 64624 (*Destruction by neurolytic agent genicular nerve branches (includes image guidance, when performed*) is a new 10-day global code which was surveyed for the January 2019 RUC meeting by the American Society of Anesthesiologists (ASA), the American Academy of Pain Medicine (AAPM), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Society of Interventional Pain Physicians (ASIPP) and the Spine Intervention Society (SIS).

Code 64624 describes the destruction of 3 different nerve branches (superomedial, inferomedial, and superolateral genicular nerve branches) at three locations (adjacent to the periosteum on the medial aspect of the tibia, and at both the medial and lateral aspects of the femur) in order to achieve analgesia for the respective knee. The code was approved at the May 2018 CPT Editorial Panel meeting.

At the October 2018 RUC meeting, the specialties noted their concern that many survey respondents appeared to be confused about the number of nerve branch injections involved with two codes in the tab: 64454 and 64624. The RUC recommended resurveying the entire tab for the January 2019 RUC meeting. Unlike the October 2018 survey, the January 2019 survey included the code's parenthetical language which indicated that code 64624 involved destruction of three different nerve branches.

A total of 69 responses were received from a random sample of 7,773 clinicians (0.8% response rate). The survey conducted was robust and captured a wide variety of specialists who regularly perform the procedure and who showed recent experience with the procedure. The societies convened an expert panel to review the survey data. ***The societies are recommending a value of 3.29 wRVUs and a time of pre (13/1/5), intra (25 min), post (10 min) and (1) 99212 office visit.*** This results in an IWPUT of: 0.089. This recommendation is based on a crosswalk to code 36578 (*Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site*).

This recommendation has been reduced in response to reviewer comments from the original recommendation of the survey median of 3.80 wRVUs.

Survey Data: wRVU and Time

The expert panel reviewed the survey data for the January 2019 RUC meeting.

64624 Highlights from January 2018 Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	2.50	3.80	4.00
Pre		20/5/5	
Intra	16	25	36
Post		10	

99 percent of the survey respondents found the vignette to be typical.

The expert panel also reviewed the survey data from the October 2018 survey.

64624 Highlights from October 2018 Survey Data			
	25th Percentile	**Median**	**75th Percentile**
Work	2.10	3.50	3.90
Pre		25/6/5	
Intra	15	20	30
Post		10	

Time Recommendations

The expert panel reviewed the survey data in developing their time recommendations.

- Pre-time: The expert panel is recommending an adjusted Facility Pre Time Package 1 (adjusted) of 13/1/5. This pre-service package is consistent with other recently and/or currently reviewed nerve treatment by injection codes such as the family of somatic nerves reviewed at the October 2018 RUC meeting.
- Intra-time: The expert panel is recommending the survey median intra time of 25 minutes. This represents an increase of 5 minutes or 25 percent from the October 2018 survey which had a median intra time of 20 minutes. The expert panel concluded that there was better understanding by survey respondents that the code described multiple injections in the more recent survey versus the October 2018 survey.
- Post time: The expert panel is recommending the survey median post time of 10 minutes. They felt this was also in-line with the post time of other recently and/or currently reviewed nerve treatment by injection codes such as the family of somatic nerves reviewed at the October 2018 RUC meeting.
- Office visit: The expert panel is recommending 1-99212 office visit. While the survey data resulted in 1-99213 office visit, the expert panel concluded that a 99212 was more appropriate and better reflected current practice.

wRVU Recommendation

In response to reviewer comments, the specialties reduced the wRVU recommendation from the original recommendation of 3.80 wRVUs (survey median) to 3.29 wRVUs.

Rationale: Crosswalk

The rationale for the recommendation of 3.29 is a crosswalk to CPT code 36578.

Code	Descriptor	Global	Pre-Time	Intra Time	Post Time	Other Hospital	Office Visits	IWPUT
36578	Replacement, catheter only, of central venous access device, with subcutaneous port or pump, central or peripheral insertion site	10	10/6/10	30	15	.5 - 99238	1-99212	0.0465

In selecting a crosswalk, the expert panel did a thorough review of the RUC database of recently reviewed, 10-day globals with intra time of around 25 minutes and found very few options. While the reviewers found that code 36578 was generally reasonable, they did find some limitations on the comparisons of these two codes. For example, while the surveyed code 64624 included imaging, the crosswalk, code 36578, does not include imaging.

Despite the limitations of this crosswalk, the expert panel did consider a number of factors in determining the reasonableness of this revised recommendation.

Building Block Analysis

In assessing the appropriateness of the value, the expert panel also considered a building block analysis of the service. Code 64624 describes ablation of three nerves (currently reported by code 64640, *Destruction by neurolytic agent; other peripheral nerve or branch*) and image guidance (currently reported by 77002, *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure*)).

- The specialties are recommending 1.98 wRVUs for code 64640 at the January 2019 meeting and code 77002 has a current value of 0.54 wRVU.
    - [(1.98) + 0.5(1.98 + 1.98) + 0.54] = 4.50 wRVUs

The building block analysis resulted in a value of 4.50 wRVU. The expert panel felt that this provided further evidence of the appropriateness of the recommendation of 3.29 wRVUs.

Relativity to Other Similar Codes Surveyed at this January 2019 RUC Meeting

In developing this recommendation, the expert panel considered a similar code being presented at this meeting. Code 6XX01 (*Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography*) is part of Tab 8. The recommendation for this code is 3.91 wRVUs. Code 6XX01 is a 10-day global that describes the ablation of four nerves around the sacroiliac joint. It has intra-time of 30 minutes. Since code 64624 describes the ablation of three nerves in the genicular area, the expert panel agreed that the wRVU difference between the two codes (3.91 versus 3.29) was appropriate.

Reference Codes

The top key reference code which was selected by 43 survey respondents was code **64633** (*Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint*) valued at 3.84 wRVUs and the second key reference code which was selected by six survey respondents was code **64632** (*Destruction by neurolytic agent; plantar common digital nerve*) valued at 1.23 wRVUs. The expert panel concluded that the recommended wRVU was supported by the reference codes selected by survey respondents.

- 64633: Code 64633 is valued at 0.55 wRVUs more than the recommended value for the surveyed code 64624 and was selected overwhelmingly by survey respondents (43 survey respondents). Code 64633 has 5 minutes more of intra service time than 64624 (30 minutes versus 25 minutes). Both codes include imaging. The expert panel agreed that the relationship between these two codes was appropriate. They noted that survey respondents indicated that the surveyed code was either the same or of greater intensity than the reference code.
- 64632: The expert panel agreed that is was appropriate for the surveyed code to be valued higher than code 64632. Code 64632 has an intra time of 5 minutes versus 25 minutes for the surveyed code. The typical patient for code 64632 is someone getting an injection in the sole of their foot while the typical patient for 64624is someone with a history of persistent knee pain. They noted that 100% of the survey respondents indicated that the surveyed code had somewhat more overall intensity/complexity.

In summary, for code 64624 the societies are recommending 3.29 wRVUs and time of pre (13/1/5), intra (25 min), post (10 min) and (1) 99212 office visit.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64640

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Anesthesiology	How often? Commonly
Specialty Interventional Pain	How often? Commonly
Specialty Pain Management	How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 52569
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on relative volume of Medicare utilization

Specialty Anesthesiology	Frequency 13842	Percentage 26.33 %
Specialty Interventional Pain	Frequency 6834	Percentage 13.00 %
Specialty Pain Management	Frequency 6429	Percentage 12.22 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 21,028 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Based on 2017 Medicare utilization

Specialty Anesthesiology	Frequency 5537	Percentage 26.33 %
Specialty Interventional Pain	Frequency 2734	Percentage 13.00 %
Specialty Pain Management	Frequency 2572	Percentage 12.23 %

Do many physicians perform this service across the United States?

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number N/A

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64640

SS Rec Summary

INSTRUCTIONS

Insert information and data into all applicable cells except IWPUT and TOTAL TIME. These cells will automatically calculate.
Hide columns and rows that do not contain data.
1st REF = Top Key Reference code data
2st REF = Second Highest Key Reference code data
CURRENT = Current data (Harvard or RUC) for code being surveyed. If this is a new code, this row will be blank.
SVY = Survey data - as it appears on the Summary of Recommendation form.
REC = Specialty Society recommended data as it appears on the Summary of Recommendation form.

ISSUE: Genicular Injection and RFA

TAB: 10

					RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
CURRENT	64450	Injection, anesthetic agent; other peripheral nerve or branch		0.083			0.75			20	10					5			5																								
SVY, October 2018	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	88	0.061	0.50	1.00	1.34	1.80	6.50	46	21	5	5	1	5	10	15	45	5																				0	12	26	60	1475
OCTOBER 2018 RUC Recommendation	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		0.090			0.75			19	7	1	1			5			5																								
JANUARY 2019 REAFFIRM, Oct 2018 RUC Recommendation	64450	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		0.090			0.75			19	7	1	1			5			5																								

					RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
1st REF	64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	35	0.066			1.52			42	7	5	5			15			10																								
2nd REF	64483	Injection(s), anesthetic agent andor steroid, transforaminal epidural, with imaging guidance (fluroscopy or CT); lumbar or sacral, single	11	0.082			1.90			49	13	5	6			15			10																								
CURRENT	64454			#DIV/0!						0																																		
SVY, October 2018	64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed	76	0.047	0.50	1.40	1.60	2.00	6.00	58	24	5	5	0	10	15	20	60	9																				0	6	20	33	500
SVY, January 2019	64454	Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed	69	0.063	1.00	1.52	1.90	2.20	10.00	55	17	5	5	1	13	18	22	55	10																				0	5	15	30	500
January 2019 Recommendati	64454	Survey 25th percentile		0.047			1.52			51	17	1	5			18			10																								

					RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
1st REF	64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	43	0.044			3.84			116	18	5	6			30			15						0.5								1											
2nd REF	64632	Destruction by neurolytic agent; plantar common digital nerve	6	0.083			1.23			36	10					5			5															1										
CURRENT	64624			#DIV/0!						0																																		
SVY, October 2018	64624	Destruction by neurolytic agent genicular nerve branches (including imaging guidance, when performed)	71	0.079	1.00	2.10	3.50	3.90	15.36	89	25	6	5	0	15	20	30	80	10														1							0	3	10	25	400
SVY, January 2019	64624	Destruction by neurolytic agent genicular nerve branches (including imaging guidance, when performed)	69	0.080	1.00	2.50	3.80	4.00	10.00	88	20	5	5	1	16	25	36	90	10														1							0	4	10	20	500
CROSSWALK	11642	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 1.1 to 2.0 cm		0.048			2.62			68	15					25			5														1											
January 2019 Recommendati	64624	CROSSWALK		0.059			2.62			74	17	1	5			25			10															1										

					RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
Source	CPT	DESC	Resp	IWPUT	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
1st REF	64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	55	0.044			3.84			116	18	5	6			30			15						0.5								1											
2nd REF	64632	Destruction by neurolytic agent; plantar common digital nerve	3	0.083			1.23			36	10					5			5															1										
CURRENT	64640	Destruction by neurolytic agent; other peripheral nerve or branch		0.083			1.23			36	10					5			5															1										
SVY, October 2018	64640	Destruction by neurolytic agent; other peripheral nerve or branch	58	0.022	1.00	1.88	2.35	3.73	9.00	88.5	24.5	6	5	1	15	20	29	80	10														1							0	4	15	30	600
SVY, January 2019	64640	Destruction by neurolytic agent; other peripheral nerve or branch	60	0.069	1.00	1.98	3.10	3.84	10.00	79.5	18	5	5	1	15	20	30	55	8.5														1							0	5	10	25	500
January 2019 Recommendation	64640	Survey 25th		0.047			1.98			64	13	1	5			20			9															1										

CPT Code:__64454, 64640, 64624_____
Specialty Society__ASA, AAPM&R, AAPM, ASIPP, SIS__

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

- 64454, Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed
- 64624, Destruction by neurolytic agent genicular nerve branches (including imaging guidance, when performed)
- 64640, Destruction by neurolytic agent; other peripheral nerve or branch

Global Period: 0 days (64454) 010 days (64640 and 64624) Meeting Date: January 2019

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   A panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Code 64454: Using the current direct PE inputs of code 64450 as the reference code
   Code 64640 and 64624: Using the current direct PE inputs of code 64640 as the reference code

3. Is this code(s) typically billed with an E/M service? *No*

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

Codes 64640 and 64624: Table, exam (default formula)

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item:

Code	Description	Explanation
CA002	Coordinate pre-surgery services (including test results)	
CA003	Schedule space and equipment in facility	
CA005	Complete pre-procedure phone calls and prescription	Staff explains where to come for the appointment, checks medications, runs through list of medical conditions, makes sure the patient is off anti-coagulation drugs, confirms if patient uses BP medications, walks the patient through the procedure, confirms whether a driver is available for a ride home and answers patient questions.
CA006	Confirm availability of prior images/studies	
CA039	Post-operative visits (total time)	
EF023	Table, exam	Used during follow-up procedure
EQ354	Radiofrequency kit for destruction by neurolytic agent	Used for the two destruction procedures

CPT Code:__64454, 64640, 64624_____
Specialty Society__ASA, AAPM&R, AAPM, ASIPP, SIS__

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

- 64454, Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed
- 64624, Destruction by neurolytic agent genicular nerve branches (including imaging guidance, when performed)
- 64640, Destruction by neurolytic agent; other peripheral nerve or branch

Global Period: 0 days (64454) 010 days (64640 and 64624) Meeting Date: January 2019

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   A panel of clinicians representing each specialty society involved in the RUC survey process for the code collaborated to develop and approve the PE recommendations.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Code 64454: Using the current direct PE inputs of code 64450 as the reference code
   Code 64640 and 64624: Using the current direct PE inputs of code 64640 as the reference code

3. Is this code(s) typically billed with an E/M service? *No.*
   Is this code(s) typically billed with the E/M service in the nonfacility? *No.*
   (Please see provided data in PE Subcommittee folder)

4. What specialty is the dominant provider in the nonfacility?
   Codes 64454 and 64624: New codes- N/A
   Code 64640: Podiatry 27%

   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Codes 64454 and 64624: New codes- N/A
   Code 64640: 45%

   Is the dominant provider in the nonfacility different then for the global?
   Codes 64454 and 64624: New codes- N/A
   Code 64640: Yes. For the global, the dominant specialty is Anesthesiology (23%)

   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

Codes 64454 and 64624: N/A
Code 64640: We are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies. Based on our Expert Panel review we identified a number of direct PE inputs (largely supplies) that are typically used when providing this service in the non-facility environment that are not currently included. We have confirmed that the added PE clinical labor tasks, supplies, and equipment are not included in the current inputs or packages and that there is no duplication.

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

   We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: BP, RR, Pulse, Temp, O2 sat.

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

Code 64454:

Technologist PACS workstation	*PACS*
mayo stand	*Default*
table, fluoroscopy	*Default*
room, mobile c-ARM	*Highly technical*
ECG, 3-channel (with SpO2, NIBP, temp, resp)	*Other*
light, exam	*Default*

The formula for ECG, 3-channel is the sum of the values included in the default formula, plus the time that the patient is monitored post-service of the service period.

Code 64640

mayo stand	*Default*
Table, power	*Default*
ECG, 3-channel (with SpO2, NIBP, temp, resp)	*Other*
light, exam	*Default*
nerve stimulator (eg, for nerve block)	*Default*
radiofrequency generator (NEURO)	*Default*
radiofrequency kit for destruction by neurolytic agent	*Default*

The formula for ECG, 3-channel is the sum of the values included in the default formula, plus the time that the patient is monitored post-service of the service period.

Code 64624

Technologist PACS workstation	*PACS*
mayo stand	*Default*
table, fluoroscopy	*Default*
room, mobile c-ARM	*Highly technical*
ECG, 3-channel (with SpO2, NIBP, temp, resp)	*Other*
light, exam	*Default*
nerve stimulator (eg, for nerve block)	*Default*
radiofrequency generator (NEURO)	*Default*
radiofrequency kit for destruction by neurolytic agent	*Default*

The formula for ECG, 3-channel is the sum of the values included in the default formula, plus the time that the patient is monitored post-service of the service period.

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

18. Please include an explanation of each line item:

Code	Description	Explanation
CA005	Complete pre-procedure phone calls and prescription	Staff explains where to come for the appointment, checks medications, runs through list of medical conditions, makes sure the patient is off anti-coagulation drugs, confirms if patient uses BP medications, walks the patient through the procedure, confirms whether a driver is available for a ride home and answers patient questions.
CA006	Confirm availability of prior images/studies	
CA009	Greet patient, provide gowning, ensure appropriate medical records are available	
CA010	Obtain vital signs	Blood pressure, respiratory rate, pulse, temperature, O2 saturation are all measured
CA011	Provide education/obtain consent	
CA013	Prepare room, equipment and supplies	Separate preparations are made by the nursing and rad tech staff for the X0 and X1 codes
CA014	Confirm order, protocol exam	
CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	
CA018	Assist physician or other qualified healthcare professional - directly	For the X0 and X1 codes, this is completed by both the nurse and the rad tech
CA022	Monitor the patient following procedure/service, multitasking 1:4	Patient is monitored for 20 minutes while multitasking (total of 5 minutes)
CA024	Clean room/equipment by clinical staff	
CA029	Check dressings, catheters, wounds	
CA030	Technologist QCs images in PACS, checking for all images, reformats, and dose page	Images are required for the X0 and X1 codes
CA031	Review examination with interpreting MD/DO	Images are required for the X0 and X1 codes
CA032	Scan exam documents in PACS. Complete exam in RIS system to populate images into work queue	Images are required for the X0 and X1 codes
CA035	Review home care instructions, coordinate visits/prescriptions	
CA039	Post-operative visits (total time)	
SB001	Cap, surgical	Sterile attire for the MD. For the destruction codes, a cap is also required for the nurse and rad tech.
SB024	Gloves, sterile	Sterile attire for the MD
SB028	Gown, surgical, sterile	Sterile attire for the MD
SB033	Mask, surgical	Sterile attire required for the MD and other staff present in the room
SB027	Gown, staff, impervious	Sterile attire for staff
SB022	Gloves, non-sterile	Sterile attire for staff
SK075	Skin marking pen, sterile (Skin Skribe)	Used to mark injection sites
SB026	Gown, patient	Used to cover patient while allowing access

		to injection site.
SB004	Cover, thermometer probe	Used for taking vitals
SB036	Paper, exam table	
SB044	Underpad 2ft x 3ft (Chux)	Used under patient to collect fluid that may drain during the procedure to the table
SB037	Pillow case	Two pillows are needed for the X0 and X1 procedures – one under the head and one between the knees
SJ081	Swab, patient prep, 1.5 ml (chloraprep)	Used to prep the injection sites
SB011	Drape, sterile, fenestrated 16in x 29in	
SB019	Drape-towel, sterile 18in x 26 in	
SB008	Drape, sterile, c-arm, fluoro	Used only for the X0 and X1 codes that require fluoroscopic guidance
SD269	Grounding pad	
SB012	Drape, sterile, for Mayo stand	Used to hold supplies during the procedures
SC029	Needle, 18-27g	Used for local anesthetic for all codes and used for the injectate for code 64640
SC051	Syringe 10-12ml	Used for the anesthetic and injectate for X0 and X1
SH047	Lidocaine 1%-2% inj (Xylocaine)	Local anesthetic – for 64640 (1 nerve) 5cc are used as well as 3cc for the injectate (8 total), for X0 and X1 (3 nerves) 10cc are used as anesthetic only.
SD050	Electrode needle, injectable (Myoject)	
SD087	Guide, needle, for localization	
SD011	Cannula (radiofrequency denervation) (SMK-C10)	Used for denervation procedures
SC028	Needle, 18-26g, 1.5-3.5in, spinal	Used for injectate for X0 code
SC057	Syringe 5-6ml	Used for anesthetic and injectate for 64640 (lower volume for single injection code)
SH021	Bupivacaine 0.25% inj (Marcaine)	Injectate, increased amount required for X0 and X1 to account for 3 nerves.
SJ001	Alcohol isopropyl 70%	Used to clean skin post-procedure
SG021	Bandage, strip 0.75in x 3in (Bandaid)	Used post-procedure for site(s) of injection
SG055	Gauze, sterile 4in x 4in	Used for the single injection (64640)
SG056	Gauze, sterile 4in x 4in (10 pack)	Used for multiple injections (X0 and X1)
SL259	Bleach cleaning wipe	Used to clean the table
EF024	Table, fluoroscopy	Used for image guided procedures X0 and X1
EF031	Table, power	Used for 64640 since imaging is not performed
EL018	Room, mobile c-Arm	
EQ354	Radiofrequency kit for destruction by neurolytic agent	Used for the two destruction procedures
EQ168	Light, exam	
ED050	Technologist PACS workstation	Used for capturing and storing images for the X0 and X1 codes
EQ214	Radiofrequency generator (NEURO)	Used during denervation procedures
EQ184	Nerve stimulator (eg, for nerve block)	Used during denervation procedures
EF015	Mayo stand	Used to hold supplies for the procedure
EQ011	ECG, 3-channel (with SpO2, NIBP, temp,	Used both during the procedure and during

	resp)	monitoring time

	A	B	C	D	E	F	G	H
1	**RUC Practice Expense Spreadsheet**						**REFERENCE CODE**	
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***					**64450**	
3		***RUC Collaboration Website***						
4	**Clinical Activity Code**	**Meeting Date: January 2019 Tab: 10 Genicular injection and RFA Specialty: ASA, AAPMR, AAPM, ASIPP, SIS**	**Standards/Guidelines**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	
5		**LOCATION**					**Non Fac**	**Facility**
6		**GLOBAL PERIOD**						
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**					**$ 19.11**	**$ 6.29**
8		**TOTAL CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37	**50.0**	**17.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37	**8.0**	**14.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37	**39.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**					**$ 18.50**	**$ 6.29**
13		**PRE-SERVICE PERIOD**						
14		**Start: Following visit when decision for surgery or procedure made**						
15	CA001	Complete pre-service diagnostic and referral forms	90 DAY: NF5, F5*	L037D	RN/LPN/MTA	0.37		3
16	CA002	Coordinate pre-surgery services (including test results)	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37		
17	CA003	Schedule space and equipment in facility	90 DAY: NF0, F8*	L037D	RN/LPN/MTA	0.37		3
18	CA004	Provide pre-service education/obtain consent	90 DAY: NF10, F20*	L037D	RN/LPN/MTA	0.37	5	5
19	CA005	Complete pre-procedure phone calls and prescription	90 DAY: NF10, F7*	L037D	RN/LPN/MTA	0.37	3	3
20	CA006	Confirm availability of prior images/studies	Standard time for this activity is 2 minutes.	L037D	RN/LPN/MTA	0.37		
21	CA007	Review patient clinical extant information and questionnaire	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37		
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	0	L037D	RN/LPN/MTA	0.37		
29		**End: When patient enters office/facility for surgery/procedure**						
30		**SERVICE PERIOD**						
31		**Start: When patient enters office/facility for surgery/procedure:**						
32		**Pre-Service (of service period)**						
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	Standard time for this activity is 3 minutes.	L037D	RN/LPN/MTA	0.37	3	
34	CA010	Obtain vital signs	Vital Sign Standards	L037D	RN/LPN/MTA	0.37	3	
35	CA011	Provide education/obtain consent	Include only the additional	L037D	RN/LPN/MTA	0.37		
36	CA012	Review requisition, assess for special needs	0	L037D	RN/LPN/MTA	0.37		
37	CA013	Prepare room, equipment and supplies	2 minute standard	L037D	RN/LPN/MTA	0.37	2	
38	CA013	Prepare room, equipment and supplies	2 minute standard	L041B	Radiologic	0.41		
39	CA014	Confirm order, protocol exam	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37		
40	CA015	Setup scope (nonfacility setting only)	5 minutes standard for scope set up in the	L037D	RN/LPN/MTA	0.37		
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2 minute standard	L037D	RN/LPN/MTA	0.37	2	
42	CA017	Sedate/apply anesthesia	2 minute standard RN/LPN/MA	L037D	RN/LPN/MTA	0.37		
49		**Intra-service (of service period)**						
50	CA018	Assist physician or other qualified healthcare professional---directly	100% of physician or other qualified	L037D	RN/LPN/MTA	0.37	5	
51	CA018	Assist physician or other qualified healthcare professional---directly	100% of physician or other qualified	L041B	Radiologic	0.41		
52	CA019	Assist physician or other qualified healthcare professional---directly	67% of physician or other qualified	L037D	RN/LPN/MTA	0.37		
53	CA020	Assist physician or other qualified healthcare professional---directly	other% of physician or other qualified	L037D	RN/LPN/MTA	0.37		
54	CA021	Perform procedure/service---NOT directly related to physician work time	0	L037D	RN/LPN/MTA	0.37		
61		**Post-Service (of service period)**						
62	CA022	Monitor patient following procedure/service, multitasking 1:4	For monitoring following procedure, the	L037D	RN/LPN/MTA	0.37	20	
63	CA023	Monitor patient following procedure/service, no multitasking	0	L037D	RN/LPN/MTA	0.37		
64	CA024	Clean room/equipment by clinical staff	3 minute standard	L037D	RN/LPN/MTA	0.37	3	
65	CA025	Clean scope	Standards For Scope Cleaning	L037D	RN/LPN/MTA	0.37		
66	CA026	Clean surgical instrument package	Standard for cleaning instruments *Must have instrument package included in	L037D	RN/LPN/MTA	0.37		
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	0	L037D	RN/LPN/MTA	0.37		
68	CA028	Review/read post-procedure x-ray, lab and pathology reports	0	L037D	RN/LPN/MTA	0.37		
69	CA029	Check dressings, catheters, wounds	Standard time for this activity is 1 minute.	L037D	RN/LPN/MTA	0.37	1	
70	CA030	Technologist QC's images in PACS, checking for all images, reformats,	Baseline time for this activity is 2 minute. For	L041B	Angio Tech	0.41		
71	CA031	Review examination with interpreting MD/DO	Standard time for this activity is 2 minute.	L041B	Angio Tech	0.41		
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to	Standard time for this activity is 1 minute.	L041B	Angio Tech	0.41		
73	CA033	Perform regulatory mandated quality assurance activity (service period)	0	L037D	RN/LPN/MTA	0.37		
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	0	L037D	RN/LPN/MTA	0.37		
75	CA035	Review home care instructions, coordinate visits/prescriptions	Standard time for this activity is 2 minutes.	L037D	RN/LPN/MTA	0.37		
76	CA036	Discharge day management	Dischrg mgmt same day (0.5 x 99238) (enter	L037D	RN/LPN/MTA	0.37	**n/a**	
83		**End: Patient leaves office**						
84		**POST-SERVICE PERIOD**						
85		**Start: Patient leaves office/facility**						
86	CA037	Conduct patient communications	Phone calls/emails/texts are in 3 minute	L037D	RN/LPN/MTA	0.37	3	3
87	CA038	Coordinate post-procedure services	0	L037D	RN/LPN/MTA	0.37		
88		***Office visits: List Number and Level of Office Visits***		**MINUTES**			**# visits**	**# visits**
89		99211 16 minutes		16				
90		99212 27 minutes		27				
91		99213 36 minutes		36				
92		99214 53 minutes		53				
93		99215 63 minutes		63				
94	CA039	Post-operative visits (total time)		L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**
101		**End: with last office visit before end of global period**						

	A	B	C	D	E	F	G	H
1	**RUC Practice Expense Spreadsheet**						**REFERENCE CODE**	
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***					**64450**	
3		***RUC Collaboration Website***						
4	**Clinical Activity Code**	**Meeting Date: January 2019 Tab: 10 Genicular injection and RFA Specialty: ASA, AAPMR, AAPM, ASIPP, SIS**	**Standards/Guidelines**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch	
5		**LOCATION**					**Non Fac**	**Facility**
6		**GLOBAL PERIOD**						
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**					**$ 19.11**	**$ 6.29**
8		**TOTAL CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37	**50.0**	**17.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37	**8.0**	**14.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37	**39.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**		L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**
102	**Supply Code**	**MEDICAL SUPPLIES**		**PRICE**	**UNIT**			
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**					**$ 0.19**	**$ -**
104	SB001	cap, surgical		0.4417	item			
105	SA041	pack, basic injection		11.365	pack			
106	SA048	pack, minimum multi-specialty visit		2.1122	pack			
107	SH023	chlorhexidine 0.12% (Peridex)		0.481	oz			
108	SH022	bupivacaine 0.5% inj (Marcaine)		0.11	ml			
109	SB024	gloves, sterile		0.8575	pair			
110	SB028	gown, surgical, sterile		4.7858	item			
111	SB033	mask, surgical		0.1745	item			
112	SB027	gown, staff, impervious		1.186	item			
113	SB022	gloves, non-sterile		0.138	pair			
114	SK075	skin marking pen, sterile (Skin Skribe)		1.191	item			
115	SB026	gown, patient		0.547	item			
116	SB004	cover, thermometer probe		0.0835	item			
117	SB036	paper, exam table		0.014	foot			
118	SB044	underpad 2ft x 3ft (Chux)		0.2525	item			
119	SB037	pillow case		0.3478	item			
120	SJ081	swab, patient prep, 1.5 ml (chloraprep)		1.0525	item			
121	SB011	drape, sterile, fenestrated 16in x 29in		0.5753	item			
122	SB019	drape-towel, sterile 18in x 26in		0.329	item			
123	SB008	drape, sterile, c-arm, fluoro		4.723	item			
124	SD269	Grounding pad		2.5925	item			
125	SB012	drape, sterile, for Mayo stand		1.5335	item			
126	SC029	needle, 18-27g		0.0767	item			
127	SC051	syringe 10-12ml		0.1905	item		1	
128	SH047	lidocaine 1%-2% inj (Xylocaine)		0.0413	ml			
129	SD050	electrode needle, injectable (Myoject)		21.2725	item			
130	SD087	guide, needle, for localization		13.385	item			
131	SD011	cannula (radiofrequency denervation) (SMK-C10)		24.8075	item			
132	SC028	needle, 18-26g 1.5-3.5in, spinal		4.9755	item			
133	SC057	syringe 5-6ml		0.145	item			
134	SH021	bupivacaine 0.25% inj (Marcaine)		0.3155	ml			
135	SJ001	alcohol isopropyl 70%		0.009	ml			
136	SG021	bandage, strip 0.75in x 3in (Bandaid)		0.1347	item			
137	SG055	gauze, sterile 4in x 4in		0.167	item			
138	SG056	gauze, sterile 4in x 4in (10 pack uou)		0.899	item			
139	SL259	Bleach cleaning wipe		0.8775	item			
140		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*						
142	**Equipment Code**	**EQUIPMENT**		**Purchase Price**	**Equipment Formula**	**Cost Per Minute**		
143		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**					**$ 0.42**	**$ -**
144	EF024	table, fluoroscopy		227650.733	Default	0.46429447		
145	EF031	table, power		6091.913		0.016166271		
146	EF023	table, exam		2188.0593	Office Visits	0.004867106	79	
147	EF023	table, exam		2188.0593	Default	0.004867106		
148	EL018	room, mobile c-ARM		151200	Highly Technical	0.572899695		
149	EQ211	pulse oximeter w-printer		1424.36		0.00459731		
150	EQ354	radiofrequency kit for destruction by neurolytic agent		2695	Default	0.040425		
151	EQ168	light, exam		1530.8117	Default	0.004062356		
152	ED050	Technologist PACS workstation		5557	PACS	0.022017924		
153	EQ214	radiofrequency generator (NEURO)		34018.25	Default	0.131825045		
154	EQ184	nerve stimulator (eg, for nerve block)		572.3	Default	0.001847174	19	
155	EF015	mayo stand		528.771	Default	0.001176195		
156	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)		4026.625	Other	0.012996464		
157		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*						

	A	B	I	J	K	L	M	N	O	P	Q
1	**RUC Practice Expense Spreadsheet**				**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**RECO**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**64450**		**64454**		**64640**		**64640**		(
3		***RUC Collaboration Website***									
4	**Clinical Activity Code**	**Meeting Date: January 2019 Tab: 10 Genicular injection and RFA Specialty: ASA, AAPMR, AAPM, ASIPP, SIS**	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed		Destruction by neurolytic agent; other peripheral nerve or branch		Destruction by neurolytic agent; other peripheral nerve or branch		Destructic agent ge branch imaging g pe
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**									
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 34.09**	**$ 5.18**	**$102.71**	**$ 5.18**	**$ 53.12**	**$ 21.14**	**$116.96**	**$ 15.30**	**$216.34**
8		**TOTAL CLINICAL STAFF TIME**	**44.0**	**14.0**	**78.0**	**14.0**	**73.0**	**57.0**	**86.0**	**41.0**	**119.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**5.0**	**11.0**	**5.0**	**11.0**	**18.0**	**30.0**	**5.0**	**11.0**	**5.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**36.0**	**0.0**	**70.0**	**0.0**	**28.0**	**0.0**	**51.0**	**0.0**	**84.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**	**3.0**	**27.0**	**27.0**	**30.0**	**30.0**	**30.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 16.28**	**$ 5.18**	**$ 29.86**	**$ 5.18**	**$ 27.01**	**$ 21.09**	**$ 31.82**	**$ 15.17**	**$ 45.31**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery or procedure made**									
15	CA001	Complete pre-service diagnostic and referral forms					5	5			
16	CA002	Coordinate pre-surgery services (including test results)		3		3	3	10		3	
17	CA003	Schedule space and equipment in facility		3		3		5		3	
18	CA004	Provide pre-service education/obtain consent					7	7			
19	CA005	Complete pre-procedure phone calls and prescription	3	3	3	3	3	3	3	3	3
20	CA006	Confirm availability of prior images/studies	2	2	2	2			2	2	2
21	CA007	Review patient clinical extant information and questionnaire									
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)									
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	3		3		3		3		3
34	CA010	Obtain vital signs	5		5		5		5		5
35	CA011	Provide education/obtain consent	3		3				3		3
36	CA012	Review requisition, assess for special needs									
37	CA013	Prepare room, equipment and supplies	2		2		5		2		2
38	CA013	Prepare room, equipment and supplies			2						2
39	CA014	Confirm order, protocol exam			1				0		1
40	CA015	Setup scope (nonfacility setting only)									
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	2		2		5		2		2
42	CA017	Sedate/apply anesthesia									
49		**Intra-service (of service period)**									
50	CA018	Assist physician or other qualified healthcare professional---directly	10		18				25		25
51	CA018	Assist physician or other qualified healthcare professional---directly			18						25
52	CA019	Assist physician or other qualified healthcare professional---directly					4				
53	CA020	Assist physician or other qualified healthcare professional---directly									
54	CA021	Perform procedure/service---NOT directly related to physician work time									
61		**Post-Service (of service period)**									
62	CA022	Monitor patient following procedure/service, multitasking 1:4	5		5				5		5
63	CA023	Monitor patient following procedure/service, no multitasking									
64	CA024	Clean room/equipment by clinical staff	3		3		3		3		3
65	CA025	Clean scope									
66	CA026	Clean surgical instrument package									
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions									
68	CA028	Review/read post-procedure x-ray, lab and pathology reports									
69	CA029	Check dressings, catheters, wounds	1		1		1		1		1
70	CA030	Technologist QC's images in PACS, checking for all images, reformats,			2						2
71	CA031	Review examination with interpreting MD/DO			2						2
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to			1						1
73	CA033	Perform regulatory mandated quality assurance activity (service period)									
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry									
75	CA035	Review home care instructions, coordinate visits/prescriptions	2		2		2		2		2
76	CA036	Discharge day management	**n/a**		**n/a**		**n/a**		**n/a**		**n/a**
83		**End: Patient leaves office**									
84		**POST-SERVICE PERIOD**									
85		**Start: Patient leaves office/facility**									
86	CA037	Conduct patient communications	3	3	3	3			3	3	3
87	CA038	Coordinate post-procedure services									
88		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes									
90		99212 27 minutes					1	1	1	1	1
91		99213 36 minutes									
92		99214 53 minutes									
93		99215 63 minutes									
94	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**	**0.0**	**27.0**	**27.0**	**27.0**	**27.0**	**27.0**
101		**End: with last office visit before end of global period**									

	A	B	I	J	K	L	M	N	O	P	Q
1	**RUC Practice Expense Spreadsheet**				**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**RECO**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.*** ***Please do not modify formulas in gray shaded cells*** ***Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**64450**		**64454**		**64640**		**64640**		(
3		***RUC Collaboration Website***									
4	**Clinical Activity Code**	**Meeting Date: January 2019** **Tab: 10 Genicular injection and RFA** **Specialty: ASA, AAPMR, AAPM, ASIPP, SIS**	Injection(s), anesthetic agent(s) and/or steroid; other peripheral nerve or branch		Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed		Destruction by neurolytic agent; other peripheral nerve or branch		Destruction by neurolytic agent; other peripheral nerve or branch		Destructic agent ge branch imaging g pe
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**									
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 34.09**	**$ 5.18**	**$102.71**	**$ 5.18**	**$ 53.12**	**$ 21.14**	**$116.96**	**$ 15.30**	**$216.34**
8		**TOTAL CLINICAL STAFF TIME**	**44.0**	**14.0**	**78.0**	**14.0**	**73.0**	**57.0**	**86.0**	**41.0**	**119.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**5.0**	**11.0**	**5.0**	**11.0**	**18.0**	**30.0**	**5.0**	**11.0**	**5.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**36.0**	**0.0**	**70.0**	**0.0**	**28.0**	**0.0**	**51.0**	**0.0**	**84.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**	**3.0**	**27.0**	**27.0**	**30.0**	**30.0**	**30.0**
102	**Supply Code**	**MEDICAL SUPPLIES**									
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ 16.48**	**$ -**	**$ 55.91**	**$ -**	**$ 25.09**	**$ -**	**$ 75.71**	**$ -**	**$ 137.70**
104	SB001	cap, surgical			1				3		3
105	SA041	pack, basic injection	1								
106	SA048	pack, minimum multi-specialty visit	1								
107	SH023	chlorhexidine 0.12% (Peridex)	1								
108	SH022	bupivacaine 0.5% inj (Marcaine)	5		5				3		5
109	SB024	gloves, sterile			1				1		1
110	SB028	gown, surgical, sterile			1				1		1
111	SB033	mask, surgical			3				2		3
112	SB027	gown, staff, impervious			1				1		1
113	SB022	gloves, non-sterile			1				2		2
114	SK075	skin marking pen, sterile (Skin Skribe)	1		1				1		1
115	SB026	gown, patient			1				1		1
116	SB004	cover, thermometer probe			1				1		1
117	SB036	paper, exam table			7				7		7
118	SB044	underpad 2ft x 3ft (Chux)			1				1		1
119	SB037	pillow case			2				1		2
120	SJ081	swab, patient prep, 1.5 ml (chloraprep)			2				1		2
121	SB011	drape, sterile, fenestrated 16in x 29in							1		
122	SB019	drape-towel, sterile 18in x 26in			4						4
123	SB008	drape, sterile, c-arm, fluoro			1						1
124	SD269	Grounding pad			1						1
125	SB012	drape, sterile, for Mayo stand			1				1		1
126	SC029	needle, 18-27g			1		1		2		1
127	SC051	syringe 10-12ml	1		2		1		0		2
128	SH047	lidocaine 1%-2% inj (Xylocaine)	5		10				8		10
129	SD050	electrode needle, injectable (Myoject)					1		1		1
130	SD087	guide, needle, for localization			1				1		1
131	SD011	cannula (radiofrequency denervation) (SMK-C10)							1		3
132	SC028	needle, 18-26g 1.5-3.5in, spinal			3						
133	SC057	syringe 5-6ml			0				2		0
134	SH021	bupivacaine 0.25% inj (Marcaine)			0				0		0
135	SJ001	alcohol isopropyl 70%	5		5				5		5
136	SG021	bandage, strip 0.75in x 3in (Bandaid)			3				1		3
137	SG055	gauze, sterile 4in x 4in	2						3		
138	SG056	gauze, sterile 4in x 4in (10 pack uou)	0		1		2				1
139	SL259	Bleach cleaning wipe			2		2		0		2
140		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*									
142	**Equipment Code**	**EQUIPMENT**									
143		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 1.33**	**$ -**	**$ 16.95**	**$ -**	**$ 1.02**	**$ 0.05**	**$ 9.43**	**$ 0.13**	**$ 33.34**
144	EF024	table, fluoroscopy			0						0
145	EF031	table, power			40				44		47
146	EF023	table, exam					115	10	0	27.0	0
147	EF023	table, exam	29								
148	EL018	room, mobile c-ARM			25						32
149	EQ211	pulse oximeter w-printer					88				
150	EQ354	radiofrequency kit for destruction by neurolytic agent							44	0.0	141
151	EQ168	light, exam			40				44		47
152	ED050	Technologist PACS workstation			45						52
153	EQ214	radiofrequency generator (NEURO)							44		47
154	EQ184	nerve stimulator (eg, for nerve block)					28		44		47
155	EF015	mayo stand	29		40				44		47
156	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	89		60				64		67
157		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*									

	A	B	R
1	**RUC Practice Expense Spreadsheet**		**MMENDED**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.*** ***Please do not modify formulas in gray shaded cells*** ***Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**64624**
3		***RUC Collaboration Website***	
4	**Clinical Activity Code**	**Meeting Date: January 2019** **Tab: 10 Genicular injection and RFA** **Specialty: ASA, AAPMR, AAPM, ASIPP, SIS**	on by neurolytic enicular nerve es (includes uidance, when formed)
5		**LOCATION**	**Facility**
6		**GLOBAL PERIOD**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 15.30**
8		**TOTAL CLINICAL STAFF TIME**	**41.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**11.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**30.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 15.17**
13		**PRE-SERVICE PERIOD**	
14		**Start: Following visit when decision for surgery or procedure made**	
15	CA001	Complete pre-service diagnostic and referral forms	
16	CA002	Coordinate pre-surgery services (including test results)	3
17	CA003	Schedule space and equipment in facility	3
18	CA004	Provide pre-service education/obtain consent	
19	CA005	Complete pre-procedure phone calls and prescription	3
20	CA006	Confirm availability of prior images/studies	2
21	CA007	Review patient clinical extant information and questionnaire	
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	
29		**End: When patient enters office/facility for surgery/procedure**	
30		**SERVICE PERIOD**	
31		**Start: When patient enters office/facility for surgery/procedure:**	
32		**Pre-Service (of service period)**	
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	
34	CA010	Obtain vital signs	
35	CA011	Provide education/obtain consent	
36	CA012	Review requisition, assess for special needs	
37	CA013	Prepare room, equipment and supplies	
38	CA013	Prepare room, equipment and supplies	
39	CA014	Confirm order, protocol exam	
40	CA015	Setup scope (nonfacility setting only)	
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	
42	CA017	Sedate/apply anesthesia	
49		**Intra-service (of service period)**	
50	CA018	Assist physician or other qualified healthcare professional---directly	
51	CA018	Assist physician or other qualified healthcare professional---directly	
52	CA019	Assist physician or other qualified healthcare professional---directly	
53	CA020	Assist physician or other qualified healthcare professional---directly	
54	CA021	Perform procedure/service---NOT directly related to physician work time	
61		**Post-Service (of service period)**	
62	CA022	Monitor patient following procedure/service, multitasking 1:4	
63	CA023	Monitor patient following procedure/service, no multitasking	
64	CA024	Clean room/equipment by clinical staff	
65	CA025	Clean scope	
66	CA026	Clean surgical instrument package	
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	
68	CA028	Review/read post-procedure x-ray, lab and pathology reports	
69	CA029	Check dressings, catheters, wounds	
70	CA030	Technologist QC's images in PACS, checking for all images, reformats,	
71	CA031	Review examination with interpreting MD/DO	
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to	
73	CA033	Perform regulatory mandated quality assurance activity (service period)	
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	
75	CA035	Review home care instructions, coordinate visits/prescriptions	
76	CA036	Discharge day management	
83		**End: Patient leaves office**	
84		**POST-SERVICE PERIOD**	
85		**Start: Patient leaves office/facility**	
86	CA037	Conduct patient communications	3
87	CA038	Coordinate post-procedure services	
88		***Office visits: List Number and Level of Office Visits***	**# visits**
89		99211 16 minutes	
90		99212 27 minutes	1
91		99213 36 minutes	
92		99214 53 minutes	
93		99215 63 minutes	
94	CA039	Post-operative visits (total time)	**27.0**
101		**End: with last office visit before end of global period**	

	A	B	R
1	**RUC Practice Expense Spreadsheet**		**MMENDED**
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below.*** ***Please do not modify formulas in gray shaded cells*** ***Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***	**64624**
3		***RUC Collaboration Website***	
4	**Clinical Activity Code**	**Meeting Date: January 2019** **Tab: 10 Genicular injection and RFA** **Specialty: ASA, AAPMR, AAPM, ASIPP, SIS**	on by neurolytic enicular nerve es (includes uidance, when rformed)
5		**LOCATION**	**Facility**
6		**GLOBAL PERIOD**	
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 15.30**
8		**TOTAL CLINICAL STAFF TIME**	**41.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**11.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**30.0**
102	**Supply Code**	**MEDICAL SUPPLIES**	
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**
104	SB001	cap, surgical	
105	SA041	pack, basic injection	
106	SA048	pack, minimum multi-specialty visit	
107	SH023	chlorhexidine 0.12% (Peridex)	
108	SH022	bupivacaine 0.5% inj (Marcaine)	
109	SB024	gloves, sterile	
110	SB028	gown, surgical, sterile	
111	SB033	mask, surgical	
112	SB027	gown, staff, impervious	
113	SB022	gloves, non-sterile	
114	SK075	skin marking pen, sterile (Skin Skribe)	
115	SB026	gown, patient	
116	SB004	cover, thermometer probe	
117	SB036	paper, exam table	
118	SB044	underpad 2ft x 3ft (Chux)	
119	SB037	pillow case	
120	SJ081	swab, patient prep, 1.5 ml (chloraprep)	
121	SB011	drape, sterile, fenestrated 16in x 29in	
122	SB019	drape-towel, sterile 18in x 26in	
123	SB008	drape, sterile, c-arm, fluoro	
124	SD269	Grounding pad	
125	SB012	drape, sterile, for Mayo stand	
126	SC029	needle, 18-27g	
127	SC051	syringe 10-12ml	
128	SH047	lidocaine 1%-2% inj (Xylocaine)	
129	SD050	electrode needle, injectable (Myoject)	
130	SD087	guide, needle, for localization	
131	SD011	cannula (radiofrequency denervation) (SMK-C10)	
132	SC028	needle, 18-26g 1.5-3.5in, spinal	
133	SC057	syringe 5-6ml	
134	SH021	bupivacaine 0.25% inj (Marcaine)	
135	SJ001	alcohol isopropyl 70%	
136	SG021	bandage, strip 0.75in x 3in (Bandaid)	
137	SG055	gauze, sterile 4in x 4in	
138	SG056	gauze, sterile 4in x 4in (10 pack uou)	
139	SL259	Bleach cleaning wipe	
140		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*	
142	**Equipment Code**	**EQUIPMENT**	
143		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ 0.13**
144	EF024	table, fluoroscopy	
145	EF031	table, power	
146	EF023	table, exam	27.0
147	EF023	table, exam	
148	EL018	room, mobile c-ARM	
149	EQ211	pulse oximeter w-printer	
150	EQ354	radiofrequency kit for destruction by neurolytic agent	0.0
151	EQ168	light, exam	
152	ED050	Technologist PACS workstation	
153	EQ214	radiofrequency generator (NEURO)	
154	EQ184	nerve stimulator (eg, for nerve block)	
155	EF015	mayo stand	
156	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	
157		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

January 2019

Radiofrequency Neurotomy Sacroiliac Joint – Tab 8

In September 2018, the CPT Editorial Panel created two new codes to describe injection and radiofrequency ablation of the sacroiliac joint with image guidance for somatic nerve procedures.

64451 ***Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)***
The RUC reviewed the survey results from 72 physicians and agreed on the following physician time components: 23 minutes of pre-service time, 15 minutes of intra-service time, and 7 minutes of immediate post-service time. This service is performed under fluoroscopic guidance, the dorsal ramus nerve is targeted at the junction of the sacral ala and superior articular process. The nerves are targeted at the posterior lateral foramen and under imaging guidance, the target areas are approached by introducing a spinal needle to each of the appropriate fluoroscopic landmarks. After negative aspiration, local anesthetic is deposited at each of the sites. The RUC thoroughly reviewed the recommended work involved in this service and agreed that the survey 25th percentile of 1.52 correctly estimates the amount of physician work involved.

To justify a work RVU of 1.52, the RUC compared the survey code to the top key reference service 64493 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (work RVU= 1.52 and intra-service time of 15 minutes) and noted that both codes have identical intra-service time and should be valued identically. The RUC noted that although the survey code has less pre- and post- service time, survey respondents rated the survey code identical to somewhat more intense than the top key reference service, warranting the same work RVU of 1.52. Additionally, the RUC compared the surveyed code to CPT code 43197 *Esophagoscopy, flexible, transnasal; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (work RVU= 1.52 and intra-service time of 15 minutes), and noted that the survey code has identical pre-service and intra-service time and nearly identical post-service time and should be valued identically. **The RUC recommends a work RVU of 1.52 for CPT code 64451.**

64625 ***Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)***
The RUC reviewed the survey results from 73 physicians and agreed on the following physician time components: 19 minutes of pre-service time, 30 minutes of intra-service time, and 7 minutes of immediate post-service time. This service is performed under fluoroscopic guidance, the dorsal ramus nerve is targeted at the junction of the sacral ala and superior articular process. The nerves are targeted at multiple points along the posterior lateral foramen and the skin around the planned entry point is injected with local anesthetic. Following the local anesthetic infiltration and under imaging guidance, a radiofrequency cannula is guided to the appropriate fluoroscopic landmark. Sensory stimulation is performed and after further anesthetic is injected, radiofrequency ablation is performed at 60 degrees for 150 seconds.

The RUC thoroughly reviewed the recommended work involved in this service and agreed that a direct work RVU crosswalk to code 67105 *Repair of retinal detachment, including drainage of subretinal fluid when performed; photocoagulation* (work RVU= 3.39, pre-service time of 11 minutes, intra-service time of 30 minutes, post-service time of 10 minutes) correctly estimates the amount of physician work involved. For additional support, the RUC also referenced CPT code 67227 *Destruction of extensive or progressive retinopathy (eg, diabetic retinopathy), cryotherapy, diathermy* (work RVU= 3.50, pre-service time of 11 minutes, intra-service time of 30 minutes, and post-service time of 10 minutes) and noted that the survey and reference code requires similar physician work to perform and should be valued similarly. **The RUC recommends a work RVU of 3.39 for CPT code 64625.**

Refer to CPT
The RUC refers codes 64451 and 64625 to the CPT Editorial Panel to clarify that these services should not be reported with electrical stimulation codes. The RUC recommends the CPT Editorial Panel editorially add codes 95873 and 95874 to the parenthetical following codes 64451 and 64625. The parenthetical following codes 64451 and 64625 should state the following:

(Do not report 64451 in conjunction with 64493, 64494, 64495, 77002, 77003, 77012, 95873, 95874)

(Do not report 64625 in conjunction with 64635, 77002, 77003, 77012, 95873, 95874)

Practice Expense
The Practice Expense (PE) Subcommittee made modifications, including correcting the clinical activity minutes for CA018, assist physician or other qualified healthcare professional---directly related to physician work time (100%) to match the intra-service time from the physician work survey, as well as to the medical supplies (SD269, SD011). PE Subcommittee members questioned including both equipment items: mobile c-ARM room (EL018) at a purchase price of $151,200 and fluoroscopy table (EF024) at a purchase price of $227,650 to perform one service with fluoroscopy. The PE Subcommittee agreed that the C-arm does not include a table, so maintained the room, mobile c-ARM (EL018), removed the table, fluoroscopy (EF024) and added in the table, power (EF031) as a proxy for fluoroscopy table until invoices can be obtained to reprice the fluoroscopy table, which PE Subcommittee members agreed should have a purchase price between $10,000 and $15,000. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

New Technology/New Services
The RUC recommends that CPT codes 64451 and 64625 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

Nervous System
Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System
Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic

(For destruction by neurolytic agent or chemodenervation, see 62280-62282, 64600-64681)

(For epidural or subarachnoid injection, see 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327)

(64400-64455, 64461, 64462, 64463, 64479, 64480, 64483, 64484, ~~64486, 64487~~, 64490-64495 are unilateral procedures. For bilateral procedures, use modifier 50)

Somatic Nerves

Codes 64400-64489 describe the introduction/injection of an anesthetic agent and/or steroid into the somatic nervous system for diagnostic or therapeutic purposes. For injection or destruction of genicular nerve branches, see 64XX0, 64XX1 respectively.

Codes 64400-64450, 64XX0 describe the injection of an anesthetic agent(s) and/or steroid into a nerve plexus, nerve, or branch. These codes are reported once per nerve plexus, nerve, or branch as described in the descriptor regardless of the number of injections performed along the nerve plexus, nerve, or branch described by the code. Image guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately.

Image guidance (ultrasound, fluoroscopy, CT) and any injection of contrast are inclusive components of 64XX0 and 64451.

Codes 64455, 64479, 64480, 64483, 64484 are reported for single or multiple injections on the same site. For 64479, 64480, 64483, 64484, image guidance (fluoroscopy or CT) and any injection of contrast are inclusive components and are not reported separately. For 64455, image guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately.

Codes 64461, 64462, 64463 describe injection of a paravertebral block (PVB). Codes 64486, 64487, 64488, 64489 describe injection of a transversus abdominis plane (TAP) block. Image guidance and any injection of contrast are inclusive components of 64461, 64462, 64463 and 64486, 64487, 64488, 64489 and are not reported separately.

◢64400	Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each ~~any~~ ~~division or~~ branch (ie, ophthalmic, maxillary, ~~or~~ mandibular)
~~64402~~	~~facial nerve~~
	(64402 has been deleted. To report injection of anesthetic agent and/or steroid to the facial nerve, use 64999)
◢64405	greater occipital nerve
◢64408	vagus nerve
~~64410~~	~~phrenic nerve~~
	(64412 has been deleted. To report, use 64999)
~~64413~~	~~cervical plexus~~
	(64410, 64413 have been deleted. To report injection of anesthetic agent and/or steroid to the phrenic nerve, cervical plexus, use 64999)
◢64415	brachial plexus~~, single~~
◢64416	brachial plexus, continuous infusion by catheter (including catheter placement)
	(Do not report 64416 in conjunction with 01996)
◢64417	axillary nerve
◢64418	suprascapular nerve
◢64420	intercostal nerve, single level
✚◢64421	intercostal nerve~~s~~, ~~multiple, regional block,~~ each additional level (List separately in addition to code for primary procedure)
	(Use 64421 in conjunction with 64420)
◢64425	ilioinguinal, iliohypogastric nerves
◢64430	pudendal nerve
◢64435	paracervical (uterine) nerve
◢64445	sciatic nerve~~, single~~

◢*64446*		*sciatic nerve, continuous infusion by catheter (including catheter placement)*		
		(Do not report 64446 in conjunction with 01996)		
◢*64447*		*femoral nerve~~, single~~*		
		(Do not report 64447 in conjunction with 01996)		
◢*64448*		*femoral nerve, continuous infusion by catheter (including catheter placement)*		
		(Do not report 64448 in conjunction with 01996)		
◢*64449*		*lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)*		
		(Do not report 64449 in conjunction with 01996)		
◢*64450*		*other peripheral nerve or branch*		
		(For injection, anesthetic agent, nerves innervating the sacroiliac joint, use 64451)		
●64451	S1	Injection(s), anesthetic agent(s) and/or steroid*;* nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) (Do not report 64451 in conjunction with 64493, 64494, 64495, 77002, 77003, 77012) (For injection, anesthetic agent, nerves innervating the sacroiliac joint with ultrasound, use 76999) (For bilateral procedure, use 64451 with modifier 50)	000	1.52
●*64XX0*		*Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches including imaging guidance, when performed* *(Do not report 64XX0 in conjunction with 64XX1)* *(64XX0 requires injecting all of the following genicular nerve branches: superolateral, superomedial, and inferomedial. If all three of these genicular nerve branches are not injected, report 64XX0 with modifier 52)*		
Paravertebral Spinal Nerves and Branches				
64493		*Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level* (For injection, anesthetic agent, nerves innervating the sacroiliac joint, use 64451)		

Nervous System
Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System
Destruction by Neurolytic Agent (eg, Chemical, Thermal, Electrical or Radiofrequency), Chemodenervation

Codes 64600-64681 include the injection of other therapeutic agents (eg, corticosteroids). Do not report diagnostic/therapeutic injections separately. Do not report a code labeled as destruction when using therapies that are not destructive of the target nerve (eg, pulsed radiofrequency), use 64999. For codes labeled as chemodenervation, the supply of the chemodenervation agent is reported separately.

(For chemodenervation of internal anal sphincter, use 46505)

(For chemodenervation of the bladder, use 52287)

(For chemodenervation for strabismus involving the extraocular muscles, use 67345)

(For chemodenervation guided by needle electromyography or muscle electrical stimulation, see 95873, 95874)

Somatic Nerves

64600 *Destruction by neurolytic agent, trigeminal nerve; supraorbital, infraorbital, mental, or inferior alveolar branch*

64605 *second and third division branches at foramen ovale*

64610 *second and third division branches at foramen ovale under the radiologic monitoring*

64625	S2	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) (Do not report 64625 in conjunction with 64635, 77002, 77003, 77012) (For radiofrequency ablation, nerves innervating the sacroiliac joint with ultrasound, use 76999) (For bilateral procedure, use 64625 with modifier 50)	010	3.39

#● *64XX1* *Destruction by neurolytic agent genicular nerve branches ~~(~~includ<u>inges</u>~~es~~ imaging guidance, when performed~~)~~*

<u>(64XX1 requires the destruction of each of the following genicular nerve branches: superolateral, superomedial, and inferomedial. If a neurolytic agent for the purposes of destruction is not applied to all of these nerve branches, report 64XX01 with modifier 52)</u>

<u>(Do not report 64XX1 in conjunction with 64XX0)</u>

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64451 Tracking Number Original Specialty Recommended RVU: **1.91**
Presented Recommended RVU: **1.91**
Global Period: 000 Current Work RVU: **N/A** RUC Recommended RVU: **1.52**

CPT Descriptor: Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male has a 5-year history of persistent right sacroiliac pain that is interfering with his ability to complete activities of daily living. He has had poor control of his pain despite multiple medication trials and physical therapy. Due to his persistent, debilitating pain, a trial of diagnostic nerve blocks to the sacroiliac joint is scheduled to relieve his pain and improve his function.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Informed consent is discussed and obtained from the patient. The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The proposed site of the procedure is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injection is prepared. The skin is cleansed with an antiseptic solution, sterile drapes are applied. The skin around the planned entry point is injected with local anesthetic. The universal protocol ("time out") is performed with the care team.

Description of Intra-Service Work: The procedure is performed under fluoroscopic guidance. The L5 dorsal ramus nerve is targeted at the junction of the sacral ala and S1 superior articular process. The S1, S2, and S3 nerves are targeted at the posterior lateral foramen of the S1, S2, and S3 foramen respectively. Under imaging guidance, the target areas are approached by introducing a spinal needle to each of the appropriate fluoroscopic landmarks. After negative aspiration, local anesthetic is deposited at each of the sites. The needle and stylet are removed.

Description of Post-Service Work: The sites are covered with a sterile occlusive dressing. The patient is observed for bleeding or any adverse effects and for evidence of successful block. A procedure note is dictated/written and medical record entries are made.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2019					
Presenter(s):	Scott Horn, DO (SIS); Wesley Ibezebo, MD (SIS); Matthew Greirson, MD (AAPM&R); Marc Leib; MD (ASA); Richard Rosenquist, MD (ASA): Eduardo Fraefield, MD (AAPM): Gregory Polston, MD (AAPM): Vijay Patel, MD (ASIPP); Karin Swartz, MD (NASS); Kano Meyer, MD (NASS)					
Specialty Society(ies):	SIS; AAPM&R; ASA; AAPM; ASIPP; NASS; NANS					
CPT Code:	64451					
Sample Size:	4110	**Resp N:**	72	**Response:** 1.7 %		
Description of Sample:	random sample					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	10.00	**22.00**	100.00	500.00
Survey RVW:	0.69	1.52	**1.91**	2.50	4.00
Pre-Service Evaluation Time:			**22.50**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	2.00	10.00	**15.00**	26.00	90.00

Immediate Post Service-Time:	**7.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	_____	99291x 99292x
Other Hospital time/visit(s):	_____	99231x 99232x 99233x
Discharge Day Mgmt:	_____	99238x 99239x 99217x
Office time/visit(s):	_____	99211x 12x 13x 14x 15x
Prolonged Services:	_____	99354x 55x 56x 57x
Sub Obs Care:	_____	99224x 99225x 99226x

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

6-NF Proc w local/topical anes care req wait time

CPT Code:	64451	**Recommended Physician Work RVU: 1.52**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**17.00**	**17.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**5.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

N/A Survey Code is Non-Facility

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**7.00**	**0.00**	**7.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64493	000	1.52	**RUC Time**

CPT Descriptor Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64479	000	2.29	**RUC Time**

CPT Descriptor Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
20611	000	1.10	**RUC Time**	1,001,062

CPT Descriptor 1 Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64479	000	2.29	**RUC Time**	45,820

CPT Descriptor 2 Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 41 **% of respondents:** 56.9 **%**

Number of respondents who choose 2nd Key Reference Code: 14 **% of respondents:** 19.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 64451	Top Key Reference CPT Code: 64493	2nd Key Reference CPT Code: **64479**
Median Pre-Service Time	9.00	17.00	24.00
Median Intra-Service Time	15.00	15.00	15.00
Median Immediate Post-service Time	7.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**31.00**	**42.00**	**49.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	7%	46%	44%	3%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	2%	54%	44%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	7%	39%	54%
Physical effort required	2%	78%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	46%	52%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	29%	57%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	36%	72%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	21%	14%	65%
Physical effort required	29%	50%	21%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	28%	72%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

64451, Injection(s), anesthetic agent(s) and/or steroid*;* nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) and 64625, Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) are new codes that describe the work involved in treating the nerves around the Sacroiliac (SI) joint. 64451 describes SI Joint

nerve treatment by injection and was approved as category I at the October 2018 CPT Editorial Panel meeting and is a 000-day global.

Both 64451 and 64625 were surveyed together by the ASA, AAPM&R, AAPM, ASIPP, NANS, NASS, and SIS for the 2019 January RUC meeting via random sampling of all societies.

Survey Results

There were 72 total respondents, and all 72 agreed with the typical patient vignette. Median experience in past 12 months was 22.

Median survey times were as follows: 22.5 minutes for pre-service evaluation, 7 minutes for pre-service positioning, 7 minutes for pre-service scrub, dress, and wait. Median intra-service time was 15 minutes with 7 minutes immediate post-service time.

25th % Work RVU was 1.52 and the Median Work RVU was 1.91.

Key Reference Services

41 of the 72 respondents choose 64493, Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level which has pre-times of 7/5/5, intra-service time of 15 minutes, and immediate post-service time of 10 minutes, a work RUV of 1.52 and an IWPUT of .068 and 14 of the 72 respondents choose 64479, Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level which has pre-times of 13/5/6, intra-service time of 15 minutes, and immediate post-service time of 10 minutes, a work RVU of 2.29 and an IWPUT of .108.

Recommended Time and Work RVU

An expert panel from all of the surveying societies reviewed the survey data and key reference services and recommends the following times and Work RVU.

We are recommending pre-service package 5, non-facility no anesthesia time (7, 0, 1), with an additional minute for positioning (7, 1, 1). This pre-service package is consistent with other recently and/or currently reviewed nerve treatment by injection codes such as the family of Somatic nerves and the family of Genicular nerves.

We are recommending the survey median intra-service time of 15 minutes.

We are recommending the survey median immediate post-service time of 7 minutes.

Our recommended total time is 31 minutes.

We are recommending the survey median Work RVU of 1.91. The resulting IWPUT is .104.

Comparison to Key Reference Services

CPT Code	Descriptor	Work RVU	Total Time	Total Pre-Time	Intra-Time	IWPUT
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	1.52	42	17	15	0.066
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level	1.9	49	24	15	0.082
6XX00	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	1.91	31	9	15	0.104
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level	2.29	49	24	15	0.108

We believe the survey conducted was robust and captured a wide variety of specialists who regularly perform the procedure and who showed a significant amount of recent experience with the procedure. We believe the median survey times and Work RVU are well supported by the key reference services like 64493 and 64483 (3rd most commonly chosen reference service from survey), and 64479. The Work RVU is higher than 64493, the most commonly chosen key reference service, but the expert panel believes it is considerably more work to treat the nerves closer to the SI joint as described by the CPT code descriptor than to treat the lumbar facets as described in 64493 which have well defined anatomical landmarks and are located further away from the joint structure and therefore are less difficult to innervate. Further, the time differences between 64451 and 64493 are a result of current RUC standard pre-time packages which not were used when 64493 was last valued when pre-times were typically the same as the median survey times. The median survey pre-times for 64451 were actually greater than the pre-times for 64493 but were adjusted to pre-service time package 5. And the survey intensity/complexity questions indicated that for many of the components, survey respondents felt 64451 to be more complex or intense than 64493.

We are recommended a work RVU that is essentially identical for 64451 as compared to 64483 with a work RVU of 1.90. 64483 has greater pre-service times, but, similar to 64493, the most recent review of 64483 occurred prior to the use of pre-service time packages and the survey median pre-service times for 64451 were actually greater than 64483 but were adjusted to pre-service package 5.

The recommended work RVU of 1.91 is lower than reference service 64479 which has a work RVU of 2.29, and the same intra-time of 15 minutes, but greater pre-service times as 64479 was last valued prior to the use of pre-service time packages. The IWPUT for 64479 -.0108- is slightly greater than the resulting IWPUT for 64451 -.104- although survey respondents indicated they considered 64451 to be more complex and intense than 64479 for most complexity/intensity questions.

These comparators indicate that the survey median Work RVU of 1.91 with pre-service package 5 (with an additional 1 minute for positioning, intra-service time of 15 minutes, and 7 minutes immediate post-service is the correct Work RVU for 64451 with the appropriate time inputs.

As an additional, final comparison, 64451 when currently performed is billed with CPT code 64450, Injection, anesthetic agent; other peripheral nerve or branch with a work RVU of 0.75. Because 64450 describes a single injection and does not include imaging guidance which is separately reportable and 64451 involves a minimum of injecting 4 nerves and includes imaging guidance, the total work RVUs are 2.15 (.75+.375+.375+.375+.27) which is higher than the median survey work RVU.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Majority of the time 64451 was reported with 64450, Injection, anesthetic agent; other peripheral nerve or branch with a smaller percentage reported with 64493, Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level or 64499, Unlisted procedure, nervous system

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pain Management How often? Commonly

Specialty Inteventional Pain Management How often? Commonly

Specialty Anesthesiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 2500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. estimates crosswalked from CPT code 64493

Specialty Pain Management Frequency 600 Percentage 24.00 %

Specialty Interventional Pain Management Frequency 575 Percentage 23.00 %

Specialty Anesthesiology Frequency 550 Percentage 22.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2500
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. estimates crosswalked from CPT code 64493

Specialty Pain Management Frequency 600 Percentage 24.00 %

Specialty Interventional Pain Management Frequency 575 Percentage 23.00 %

Specialty Anesthesiology Frequency 550 Percentage 22.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 64493

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:64625 Tracking Number Original Specialty Recommended RVU: **3.91**
Presented Recommended RVU: **3.84**
Global Period: 010 Current Work RVU: **N/A** RUC Recommended RVU: **3.39**

CPT Descriptor: Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 68-year-old male has a 5-year history of persistent right sacroiliac joint pain and struggles to complete activities of daily living. He has had poor pain control despite multiple medication trials and physical therapy. Subsequently, a trial of diagnostic nerve blocks was conducted which temporarily relieved his pain and improved his function. He is now scheduled for radiofrequency ablation of the nerves innervating the sacroiliac joint to provide longer term, sustained pain relief.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 29% , In the ASC 38%, In the office 33%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 100% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Informed consent is discussed and obtained from the patient. The clinician obtains and reviews the medical record and any pertinent imaging studies, laboratory studies and medical information. The proposed site of the procedure is identified and marked. The patient is moved to the procedure room. The clinician gowns, gloves and prepares supplies. The injection is prepared. The skin is cleansed with an antiseptic solution, sterile drapes are applied. The skin around the planned entry point is injected with local anesthetic. The universal protocol ("time out") is performed with the care team..

Description of Intra-Service Work: The procedure is performed under fluoroscopic guidance. The L5 dorsal ramus nerve is targeted at the junction of the sacral ala and S1 superior articular process. The S1, S2, and S3 nerves are targeted at multiple points along the posterior lateral foramen of the S1, S2, and S3 foramen respectively. Under imaging guidance, a radiofrequency cannula is guided to the appropriate fluoroscopic landmark. Sensory stimulation is performed. After further anesthetic is injected, radiofrequency ablation is performed at 60 degrees for 150 seconds. The needle and stylet are removed.

Description of Post-Service Work: The sites are covered with a sterile occlusive dressing. The patient is observed for bleeding or any adverse effects and for evidence of successful radiofrequency ablation. A procedure note is dictated/written and medical record entries are made. The patient is discharged after a period of monitoring and when there is independent ambulation. At the follow-up office visit, the patient is examined and treatment success or adverse reactions that may have occurred after the procedure are discussed. Revise the treatment plan(s) as necessary. Dictate notes for the patient’s medical record..

SURVEY DATA

RUC Meeting Date (mm/yyyy)	01/2019					
Presenter(s):	Scott Horn, DO (SIS); Wesley Ibezebo, MD (SIS); Matthew Greirson, MD (AAPM&R); Marc Leib; MD (ASA); Richard Rosenquist, MD (ASA): Eduardo Fraefield, MD (AAPM): Gregory Polston, MD (AAPM): Vijay Patel, MD (ASIPP); Karin Swartz, MD (NASS); Kany Meyer, MD (NASS)					
Specialty Society(ies):	SIS; AAPM&R; ASA; AAPM; ASIPP; NASS; NANS					
CPT Code:	64625					
Sample Size:	4110	**Resp N:**	73	**Response:** 1.7 %		
Description of Sample:	random sample					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**10.00**	50.00	100.00
Survey RVW:	1.50	3.00	**3.91**	4.25	6.05
Pre-Service Evaluation Time:			**22.00**		
Pre-Service Positioning Time:			**5.00**		
Pre-Service Scrub, Dress, Wait Time:			**5.00**		
Intra-Service Time:	2.00	20.00	**30.00**	40.00	60.00

Immediate Post Service-Time:	**7.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.50** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

1-FAC Straightforw Pat/Procedure(no sedate/anesth

CPT Code:	64625	**Recommended Physician Work RVU: 3.39**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**13.00**	**13.00**	**0.00**
Pre-Service Positioning Time:		**1.00**	**1.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**5.00**	**6.00**	**-1.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

7A Local/Simple Procedure

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**7.00**	**18.00**	**-11.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**19.00**	99238x **0.5** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**23.00**	99211x **0.00** 12x **0.00** 13x **1.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64633	010	3.84	**RUC Time**

CPT Descriptor Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
64561	010	5.44	**RUC Time**

CPT Descriptor Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64635	010	3.78	**RUC Time**	314,114

CPT Descriptor 1 Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64561	010	5.44	**RUC Time**	15,344

CPT Descriptor 2 Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed

Other Reference CPT Code	Global	Work RVU	Time Source
46505	010	3.50	**RUC Time**

CPT Descriptor Chemodenervation of internal anal sphincter

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 57 **% of respondents:** 78.0 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 9.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 64625	Top Key Reference CPT Code: 64633	2nd Key Reference CPT Code: **64561**
Median Pre-Service Time	19.00	29.00	32.00
Median Intra-Service Time	30.00	30.00	45.00
Median Immediate Post-service Time	7.00	15.00	19.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	19.0	19.00	0.00
Median Office Visit Time	23.0	23.00	40.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**98.00**	**116.00**	**136.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	2%	34%	61%	13%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	56%	31%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	8%	34%	58%
Physical effort required	2%	26%	72%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	19%	42%	39%

2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	14%	43%	29%	14%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	14%	57%	29%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	71%	14%
Physical effort required	14%	43%	43%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	43%	43%	14%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

64451, Injection(s), anesthetic agent(s) and/or steroid*;* nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) and 64625, Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography) are new codes that describe the work involved in treating the nerves around the Sacroiliac (SI) joint. 64625 describes SI Joint

nerve treatment by radiofrequency ablation and was approved as category I at the October 2018 CPT Editorial Panel meeting and is a 010-day global.

Both 64451 and 64625 were surveyed together by the ASA, AAPM&R, AAPM, ASIPP, NANS, NASS, and SIS for the 2019 January RUC meeting via random sampling of all societies.

Survey Results

There were 73 total respondents, and 71 of the 73 respondents agreed with the typical patient vignette. Median experience in past 12 months was 10.

Median survey times were as follows: 22 minutes for pre-service evaluation, 7 minutes for pre-service positioning, 7 minutes for pre-service scrub, dress, and wait. Median intra-service time was 30 minutes with 7 minutes immediate post-service time. Survey respondents indicated the most typical site of service to be the Ambulatory Surgical Center (ASC) with the patient being discharged on the same day in 100% of the cases. Survey respondents indicated one post-operative follow up visit in the office setting in the global period at a 99213 level.

25th % Work RVU was 3.00 and the Median Work RVU was 3.91.

Key Reference Services

57 of the 73 respondents choose 64633, Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint which has pre-times of 18/5/6, intra-service time of 30 minutes, and immediate post-service time of 15 minutes, half day discharge, 1 post-operative office visit, 99213, a work RUV of 3.84, and an IWPUT of .044.

7 of the 73 respondents choose 64561, Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed which has pre-times of 13/5/6, intra-service time of 45 minutes, immediate post-service time of 19 minutes, one level 99214 post-operative office visit, a work RVU of 5.44 and an IWPUT of .064.

Recommended Time and Work RVU

An expert panel from surveying societies reviewed the survey data and key reference services and recommends the following times and Work RVU.

We are recommending pre-service package 1-Facility, straightforward patient, no general anesthesia, with a reduction of one minute for scrub, dress, and wait to reflect survey median times (13, 1, 5). This pre-service package is consistent with other recently and/or currently reviewed nerve treatment by injection codes such as the family of Somatic nerves and the family of Genicular nerves.

We are recommending the survey median intra-service time of 30 minutes.

We are recommending the survey median immediate post-service time of 7 minutes with a corresponding reduction from post-service package 7A of -11 minutes to reflect median survey responses. We are also recommending a half-day discharge-99238 to reflect the typical site of service from the survey, and one post-operative office visit-99213 to reflect the survey responses.

Our recommended total time is 98 minutes.

We are recommending the survey median Work RVU of 3.91. The resulting IWPUT is .060.

Comparison to Key Reference Services

CPT Code	Descriptor	Work RVU	Total Time	Total Pre-Time	Intra-Time	IWPUT	SVY
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	3.84	116	29	30	0.044	SVY
6XX01	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	3.91	98	19	30	0.06	SVY
64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	5.44	136	32	45	0.064	SVY

We believe the survey conducted was robust and captured a wide variety of specialists who regularly perform the procedure and who showed a significant amount of recent experience with the procedure. We believe the median survey times and recommended Work RVU are well supported by the key reference service 64633 which was chosen by 78% of the respondents. The recommended Work RVU is slightly higher than 64633, the most commonly chosen key reference service. The expert panel believes it is more work to treat the nerves closer to the SI joint as described by the CPT code descriptor than to treat the cervical or thoracic medial branch nerves as described in 64633 which are which have well defined anatomical landmarks and are located further away from the joint structure and therefore are less difficult to innervate. Further, the time differences between 64625 and 64633 are a result of current RUC standard pre-time packages which were not used when 64633 was last valued when pre-times were typically the same as the median survey times. The median survey pre-times for 64625 were actually greater than the pre-times for 64633 but were adjusted to pre-service time package 1. And the survey intensity/complexity questions indicated that for most of the components, survey respondents felt 64625 to be more complex or intense than 64633.

These comparators indicate that the survey median Work RVU of 3.91 with pre-service package 1 (with a subtraction of 1 minute for scrub, dress and wait, intra-service time of 15 minutes, post-service package 7a with 11 minutes subtracted, a half-day discharge-99238, and one post-operative office visit 99213 are the correct and appropriate Work RVU and times for 64625.

Compelling Evidence Rationale for 64625

Currently, clinicians are reported services described by code 64625 either with code 64640 Destruction by neurolytic agent; other peripheral nerve or branch) or 64633, Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint. Code 64640 is currently being surveyed for this meeting as part of a different tab (tab 10). It was previously surveyed back in 2011. The American Society of Anesthesiologists (ASA), the American Academy of Pain Medicine (AAPM), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Society of Interventional Pain Physicians (ISIPP), the North American Neuromodulation Society (NANS), the North American Spine Society (NASS) and the Spine Intervention Society (SIS) are submitting compelling evidence for code 64625.

Change in physician work due to change in patient population

There is a change in physician work due to a change in the typical patient. When 64640 was surveyed in 2011, the typical patient had a history of neuritis of the medial calcaneal nerve.

- 64640 Current Vignette: A 50-year-old female has a history of neuritis of the medial calcaneal nerve. Her symptoms, including paresthesia on percussion and ambulation, have failed to improve following administration of multiple conservative treatment modalities. The decision is made to perform a percutaneous alcohol nerve sclerosing (PANS) injection.

In contrast, the typical patient for 64625 is experiencing persistent SI right sacroiliac joint pain.

- 64625 Vignette: A 68-year-old male has a 5-year history of persistent right sacroiliac joint pain and struggles to complete activities of daily living. He has had poor pain control despite multiple medication trials and physical therapy. Subsequently, a trial of diagnostic nerve blocks was conducted which temporarily relieved his

pain and improved his function. He is now scheduled for radiofrequency ablation of the nerves innervating the sacroiliac joint to provide longer term, sustained pain relief.

Existing codes are not specific to the SI Joint Nerve RFA procedure where the SI Joint Nerve branches are targeted for radiofrequency ablation. This service is performed on a subset of patients who experienced temporary relief from pain from a previous SI Joint Nerve block procedure.

Change in physician work due to change in technique
There is a change in physician work due to change in technique. The work description for code 64640 describes a single ablation. Code 64625, involves ablation for a minimum of 4 SI joint nerve branches in order to achieve analgesia for the SI Joint.

Specialties surveyed
All of the specialties that currently perform the 64625, were not included in the 2011 survey for 64640. The specialties that surveyed the code in 2011 included podiatry, anesthesia, pain management and interventional pain management. For the new code 64625, the specialty of podiatry does not perform the service and their inclusion would not be appropriate. Additionally, physical medicine and rehabilitation was not included in the 2011 survey. They are included in the 2018 survey along with specialists in neuromodulation (NANS), and spine surgery (NASS).

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 64640, 64633

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pain Management How often? Commonly

Specialty Inteventional Pain Management How often? Commonly

Specialty Anesthesiology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period? 2000
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. estimated crosswalk from 64633

Specialty Pain Management Frequency 560 Percentage 28.00 %

Specialty Interventional Pain Management Frequency 540 Percentage 27.00 %

Specialty Anesthesiology Frequency 520 Percentage 26.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. estimated crosswalk from 64633

Specialty Pain Management Frequency 560 Percentage 28.00 %

Specialty Interventional Pain Management Frequency 540 Percentage 27.00 %

Specialty Ansethsiology Frequency 520 Percentage 26.00 %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Minor procedure

BETOS Sub-classification Level II:
Musculoskeletal

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 64633

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: RadioFrequncy Neurotomy Sacroliliac Joint

TAB: 8

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	-inpt/same 32	-inpt/same 38	FAC-obs 26	FAC-obs 25	FAC-obs 17	Office 15	Office 14	Office 13	Office 12	Office 11	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level	41	0.066			1.52			42	7	5	5			15			10															
2nd REF	64479	Injection(s), anesthetic agent andor steroid, transforaminal epidural, with imaging guidance (fluroscopy or CT); lumbar or sacral, single level	14	0.108			2.29			49	13	5	6			15			10															
CURRENT	64451			#DIV/0!						0																								
SVY	64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	72	0.073	0.69	1.52	1.91	2.50	4.00	54.5	22.5	5	5	2	10	15	26	90	7											0	10	22	100	500
Revised Rec		25th % Survey work RVU		0.061			1.52			45	17	1	5			15			7															

Source	CPT	DESC	Resp	IWPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	-inpt/same 32	-inpt/same 38	FAC-obs 26	FAC-obs 25	FAC-obs 17	Office 15	Office 14	Office 13	Office 12	Office 11	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	57	0.044			3.84			116	18	5	6			30			15		0.5						1								
2nd REF	64561	Percutaneous implantation of neurostimulator electrode array; sacral nerve (transforaminal placement) including image guidance, if performed	7	0.064			5.44			136	22	5	5			45			19							1								
CURRENT	64625			#DIV/0!						0																								
SVY	64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	73	0.050	1.50	3.00	3.91	4.25	6.05	111	22	5	5	2	20	30	40	60	7		0.5						1			0	5	10	50	500
Revised Rec		cross walk to 67105		0.042			3.39			98	13	1	5			30			7		0.5						1							

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

Global Period: 0 days (64451) 010 days (64625) Meeting Date: January 2019

64451: Injection(s), anesthetic agent(s) and/or steroid*;* nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

64625: Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   A panel of clinicians representing each specialty society involved in the RUC survey process for the collaborated to develop and approve the PE recommendations.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Code 64451: Using the current direct PE inputs of code 64493 as the reference code. 64493 was the primary reference code from the RUC survey.
   Code 64625: Using the current direct PE inputs of code 64633 as the reference code. 64633 was the primary reference code from the RUC survey.

3. Is this code(s) typically billed with an E/M service? *No*

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

5. If you are requesting an increase over the current total cost for clinical staff time (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), total cost of supplies, and/or total cost of equipment you must provide compelling evidence: *N/A*

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

7. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

8. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

9. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

10. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

11. List all the equipment included in your recommendation and the equipment formula chosen (see document titled "Calculating equipment time"). If you have selected "other formula" for any of the equipment please explain here:

Code 64625: Table, exam (default formula)

12. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

13. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

14. Please include an explanation of each line item:

Code	Description	Explanation
CA002	Coordinate pre-surgery services (including test results)	Staff ensures all clinicians and providers have the relevant test results and other necessary components to delivery service
CA003	Schedule space and equipment in facility	Staff schedules and reviews space in facility as well as necessary equipment for performance of the procedure
CA005	Complete pre-procedure phone calls and prescription	Staff explains where to come for the appointment, checks medications, runs through list of medical conditions, makes sure the patient is off anti-coagulation drugs, confirms if patient uses BP medications, walks the patient through the procedure, confirms whether a driver is available for a ride home and answers patient questions.
CA006	Confirm availability of prior images/studies	Staff review medical records and confirm that all relevant prior images and studies are available for provider and obtains prior images and studies when necessary
CA039	Post-operative visits (total time)	
EF023	Table, exam	Used during follow-up procedure
EQ354	Radiofrequency kit for destruction by neurolytic agent	Used for the destruction procedure

CPT Code:__64451, 64625_____
Specialty Society__ASA, AAPM&R, AAPM, ASIPP, SIS, NASS, NANS__

AMA/Specialty Society Update Process
Practice Expense Summary of Recommendation (SoR)
Non Facility Direct Practice Expense (PE) Inputs

CPT Long Descriptor:

64451: Injection(s), anesthetic agent(s) and/or steroid*;* nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

64625: Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

Global Period: 0 days (64451) 010 days (64625) Meeting Date: January 2019

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   A panel of clinicians representing each specialty society involved in the RUC survey process for the collaborated to develop and approve the PE recommendations.

2. You must provide reference code(s) for comparison on your spreadsheet. If the code you are making recommendations on is not new, you must use the current direct PE inputs as your reference code. You can provide one additional reference code if you are required to use the current direct PE inputs. Provide an explanation for the selection of reference code(s) here:

   Code 64451: Using the current direct PE inputs of code 64493 as the reference code. 64493 was the primary reference code from the RUC survey.
   Code 64625: Using the current direct PE inputs of code 64633 as the reference code. 64633 was the primary reference code from the RUC survey.

3. Is this code(s) typically billed with an E/M service? *No.*
   Is this code(s) typically billed with the E/M service in the nonfacility? *No.*
   (Please see provided data in PE Subcommittee folder)

4. What specialty is the dominant provider in the nonfacility?
   Codes 64451 and 64625: New codes- N/A

   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Codes 64451 and 64625: New codes- N/A

   Is the dominant provider in the nonfacility different then for the global?
   Codes 64451 and 64625: New codes- N/A

   (Please see provided data in PE Subcommittee folder)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time: *N/A*

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies (This does not include minutes to assist physician and the number of post-op visits, as they are directly related to physician work), you must provide compelling evidence. Please explain if the increase can be entirely accounted for because of an increase in physician time.

   Codes 64451 and 64625: N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and listed in tab 2, please explain the difference here: *N/A*

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? (please use this time rather than 5 minutes in your reference code)
   The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

   We recommend 5 minutes for obtaining vital signs. The following vital signs are collected: BP, RR, Pulse, Temp, O2 sat.

9. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *Assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

   Staff is present and assisting physician during the entire procedure. Staff supports the physician throughout the procedure by handing over the necessary supplies (syringes, gauzes etc.), acts as a second pair of hands during the procedure assisting with supplies/equipment or directly with the patient as needed, helps to make sure patient is comfortable and monitors the patient throughout the procedure.

10. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived. *N/A*

11. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities: *N/A*

12. If you wish to identify a new staff type, please include a very specific staff description, a salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov. *N/A*

13. If you wish to include a supply that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

14. If you wish to include an equipment item that is not on the list please provide a paid invoice. Identify and explain the invoice here: *N/A*

15. List all the equipment included in your recommendation and the equipment formula chosen (see document titled “Calculating equipment time”). If you have selected “other formula” for any of the equipment please explain here:

Code 64451:

Technologist PACS workstation	*PACS*
mayo stand	*Default*
table, fluoroscopy	*Default*
room, mobile c-ARM	*Highly technical*
ECG, 3-channel (with SpO2, NIBP, temp, resp)	*Other*
light, exam	*Default*

The formula for ECG, 3-channel is the sum of the values included in the default formula, plus the time that the patient is monitored post-service of the service period.

Code 64625

Technologist PACS workstation	*PACS*
mayo stand	*Default*
table, fluoroscopy	*Default*
ECG, 3-channel (with SpO2, NIBP, temp, resp)	*Other*
light, exam	*Default*
nerve stimulator (eg, for nerve block)	*Default*
radiofrequency generator (NEURO)	*Default*
radiofrequency kit for destruction by neurolytic agent	*Default*

The formula for ECG, 3-channel is the sum of the values included in the default formula, plus the time that the patient is monitored post-service of the service period.

16. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail please include here: *N/A*

17. If there is any other item on your spreadsheet that needs further explanation please include here: *N/A*

18. Please include an explanation of each line item:

Code	Description	Explanation
CA005	Complete pre-procedure phone calls and prescription	Staff explains where to come for the appointment, checks medications, runs through list of medical conditions, makes sure the patient is off anti-coagulation drugs, confirms if patient uses BP medications, walks the patient through the procedure, confirms whether a driver is available for a ride home and answers patient questions.
CA006	Confirm availability of prior images/studies	
CA009	Greet patient, provide gowning, ensure appropriate medical records are available	
CA010	Obtain vital signs	Blood pressure, respiratory rate, pulse, temperature, O2 saturation are all measured
CA011	Provide education/obtain consent	Patient and/or caregiver education on procedure, risks, complications, and

		requirements; obtain consent signature/approval subsequent to education
CA013	Prepare room, equipment and supplies	Separate preparations are made by the nursing and rad tech staff for the XX00 and XX01 codes
CA014	Confirm order, protocol exam	Confirm order is correct
CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	For both the XX00 and XX01, initiate IV, assist in patient positioning and monitor patient IV feed, and patient position
CA018	Assist physician or other qualified healthcare professional - directly	For the XX00 and XX01 codes, this is completed by both the nurse and the rad tech
CA022	Monitor the patient following procedure/service, multitasking 1:4	Patient is monitored for 20 minutes while multitasking (total of 5 minutes)
CA024	Clean room/equipment by clinical staff	Room and equipment are cleaned after patient encounter
CA029	Check dressings, catheters, wounds	Patient's dressings and wounds checked
CA030	Technologist QCs images in PACS, checking for all images, reformats, and dose page	Images are required for the XX00 and XX01 codes
CA031	Review examination with interpreting MD/DO	Images are required for the XX00 and XX01 codes
CA032	Scan exam documents in PACS. Complete exam in RIS system to populate images into work queue	Images are required for the XX00 and XX01 codes
CA035	Review home care instructions, coordinate visits/prescriptions	Post procedure review of care instructions with patient and/or caregiver and coordination of future visits and related precriptions
CA039	Post-operative visits (total time)	
SB001	Cap, surgical	Sterile attire for the MD. For the destruction codes, a cap is also required for the nurse and rad tech.
SB024	Gloves, sterile	Sterile attire for the MD
SB028	Gown, surgical, sterile	Sterile attire for the MD
SB033	Mask, surgical	Sterile attire required for the MD and other staff present in the room
SB027	Gown, staff, impervious	Sterile attire for staff
SB022	Gloves, non-sterile	Sterile attire for staff
SK075	Skin marking pen, sterile (Skin Skribe)	Used to mark injection sites
SB026	Gown, patient	Used to cover patient while allowing access to injection site.
SB004	Cover, thermometer probe	Used for taking vitals
SB036	Paper, exam table	
SB044	Underpad 2ft x 3ft (Chux)	Used under patient to collect fluid that may drain during the procedure to the table
SB037	Pillow case	Two pillows are needed for the XX00 and XX01 procedures – one under the head and one between the knees
SJ081	Swab, patient prep, 1.5 ml (chloraprep)	Used to prep the injection sites
SB011	Drape, sterile, fenestrated 16in x 29in	
SB019	Drape-towel, sterile 18in x 26 in	

SB008	Drape, sterile, c-arm, fluoro	Used only for the XX00 and XX01 codes that require fluoroscopic guidance
SD269	Grounding pad	
SB012	Drape, sterile, for Mayo stand	Used to hold supplies during the procedures
SC051	Syringe 10-12ml	Used for the anesthetic and injectate for XX00 and XX01
SH047	Lidocaine 1%-2% inj (Xylocaine)	Local anesthetic –for XXX000 and XXX000 (4 nerves) 10cc are used as anesthetic only.
SD050	Electrode needle, injectable (Myoject)	
SD087	Guide, needle, for localization	
SD011	Cannula (radiofrequency denervation) (SMK-C10)	Used for denervation procedures
SC028	Needle, 18-26g, 1.5-3.5in, spinal	Used for injectate for XX00 code
SH021	Bupivacaine 0.25% inj (Marcaine)	Injectate, increased amount required for XX00 and XX01 to account for 4 nerves.
SJ001	Alcohol isopropyl 70%	Used to clean skin post-procedure
SG021	Bandage, strip 0.75in x 3in (Bandaid)	Used post-procedure for site(s) of injection
SG056	Gauze, sterile 4in x 4in (10 pack)	Used for multiple injections (XX00 and XX01)
SL259	Bleach cleaning wipe	Used to clean the table
EF024	Table, fluoroscopy	Used for image guided procedures XX00 and XX01
EL018	Room, mobile c-Arm	Used for injection procedure XX00
EQ354	Radiofrequency kit for destruction by neurolytic agent	Used for destruction procedure XX01
EQ168	Light, exam	
ED050	Technologist PACS workstation	Used for capturing and storing images for the XX00 and XX01 codes
EQ214	Radiofrequency generator (NEURO)	Used during denervation procedure XX01
EQ184	Nerve stimulator (eg, for nerve block)	Used during denervation procedure XX01
EF015	Mayo stand	Used to hold supplies for the procedures
EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	Used both during the procedures and during monitoring time

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**64493**		**64451**		**64633**		**64625**	
3		***RUC Collaboration Website***				Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level		Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint		Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	
4	**Clinical Activity Code**	**Meeting Date: January 2019 Tab: 8: RFA Neurotomy Sacroiliac Joint Specialty: ASA, AAPMR, AAPM, ASIPP, SIS, NANS, NASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**											
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 61.74**	**$ 8.88**	**$ 95.03**	**$ 4.07**	**$ 93.50**	**$ 21.41**	**$ 251.70**	**$ 17.57**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**67.0**	**24.0**	**68.0**	**11.0**	**106.0**	**57.0**	**134.0**	**47.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**11.0**	**21.0**	**5.0**	**11.0**	**11.0**	**21.0**	**5.0**	**11.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**53.0**	**0.0**	**63.0**	**0.0**	**59.0**	**0.0**	**93.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**0.0**	**0.0**	**36.0**	**36.0**	**36.0**	**36.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 24.79**	**$ 8.88**	**$ 26.04**	**$ 4.07**	**$ 39.22**	**$ 21.09**	**$ 51.06**	**$ 17.39**
13		**PRE-SERVICE PERIOD**											
14		**Start: Following visit when decision for surgery or procedure made**											
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37								
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37				3				3
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37				3				3
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37								
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37			3	3			3	3
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37			2	2			2	2
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37								
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37	11	21			11	21		
29		**End: When patient enters office/facility for surgery/procedure**											
30		**SERVICE PERIOD**											
31		**Start: When patient enters office/facility for surgery/procedure:**											
32		**Pre-Service (of service period)**											
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are	L037D	RN/LPN/MTA	0.37			3				3	
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37			5				5	
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37			2				2	
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37								
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37			2				2	
38	CA013	Prepare room, equipment and supplies	L041B	Radiologic	0.41			2				2	
39	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37			1				1	
40	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37								
41	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37			2				2	
42	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37								
49		**Intra-service (of service period)**											
50	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37			15				30	
51	CA018	Assist physician or other qualified healthcare professional---directly	L041B	Radiologic	0.41			15				30	
52	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37								
53	CA020	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37								
54	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37	53				59			
61		**Post-Service (of service period)**											
62	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37			5				5	
63	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37								
64	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37			3				3	
65	CA025	Clean scope	L037D	RN/LPN/MTA	0.37								
66	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37								
67	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37								

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**64493**		**64451**		**64633**		**64625**	
3		***RUC Collaboration Website***				Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level		Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint		Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	
4	**Clinical Activity Code**	**Meeting Date: January 2019 Tab: 8: RFA Neurotomy Sacroiliac Joint Specialty: ASA, AAPMR, AAPM, ASIPP, SIS, NANS, NASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**											
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 61.74**	**$ 8.88**	**$ 95.03**	**$ 4.07**	**$ 93.50**	**$ 21.41**	**$ 251.70**	**$ 17.57**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**67.0**	**24.0**	**68.0**	**11.0**	**106.0**	**57.0**	**134.0**	**47.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**11.0**	**21.0**	**5.0**	**11.0**	**11.0**	**21.0**	**5.0**	**11.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**53.0**	**0.0**	**63.0**	**0.0**	**59.0**	**0.0**	**93.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**0.0**	**0.0**	**36.0**	**36.0**	**36.0**	**36.0**
68	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37								
69	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37			1				1	
70	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	L041B	Angio Tech	0.41			2				2	
71	CA031	Review examination with interpreting MD/DO	L041B	Angio Tech	0.41			2				2	
72	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue.	L041B	Angio Tech	0.41			1				1	
73	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37								
74	CA034	Document procedure (nonPACS) (e.g. mandated reporting, registry	L037D	RN/LPN/MTA	0.37								
75	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37			2				2	
76	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**		**n/a**	
83		**End: Patient leaves office**											
84		**POST-SERVICE PERIOD**											
85		**Start: Patient leaves office/facility**											
86	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37								
87	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37	3	3			36	36		
88		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
89		99211 16 minutes	16										
90		99212 27 minutes	27										
91		99213 36 minutes	36									1	1
92		99214 53 minutes	53										
93		99215 63 minutes	63										
94	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**36.0**	**36.0**
101		**End: with last office visit before end of global period**											

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
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4	**Clinical Activity Code**	**Meeting Date: January 2019** **Tab: 8: RFA Neurotomy Sacroiliac Joint** **Specialty: ASA, AAPMR, AAPM, ASIPP, SIS, NANS, NASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**											
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 61.74**	**$ 8.88**	**$ 95.03**	**$ 4.07**	**$ 93.50**	**$ 21.41**	**$ 251.70**	**$ 17.57**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**67.0**	**24.0**	**68.0**	**11.0**	**106.0**	**57.0**	**134.0**	**47.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**11.0**	**21.0**	**5.0**	**11.0**	**11.0**	**21.0**	**5.0**	**11.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**53.0**	**0.0**	**63.0**	**0.0**	**59.0**	**0.0**	**93.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**0.0**	**0.0**	**36.0**	**36.0**	**36.0**	**36.0**
102	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**									
103		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 5.42**	**$ -**	**$ 54.89**	**$ -**	**$ 45.94**	**$ -**	**$ 164.08**	**$ -**
104	SA041	pack, basic injection	11.365	pack		1				1			
105	SA048	pack, minimum, multi-specialty visit	2.1122	pack		1				2			
106	SB001	cap, surgical	0.4417	item				1				3	
107	SB008	drape, c-arm flouro	4.723	item						1			
108	SB024	gloves, sterile	0.8575	pair				1				1	
109	SB028	gown, surgical, sterile	4.7858	item				1				1	
110	SB033	mask, surgical	0.1745	item				3				3	
111	SB027	gown, staff, impervious	1.186	item				1				1	
112	SB022	gloves, non-sterile	0.138	pair				1				2	
113	SK075	skin marking pen, sterile (Skin Skribe)	1.191	item				1				1	
114	SB026	gown, patient	0.547	item				1				1	
115	SB004	cover, thermometer probe	0.0835	item				1				1	
116	SB036	paper, exam table	0.014	foot				7				7	
117	SB044	underpad 2ft x 3ft (Chux)	0.2525	item				1				1	
118	SB037	pillow case	0.3478	item				2				2	
119	SJ081	swab, patient prep, 1.5 ml (chloraprep)	1.0525	item				2				2	
120	SB011	drape, sterile, fenestrated 16in x 29in	0.5753	item									
121	SB019	drape-towel, sterile 18in x 26in	0.329	item				4				4	
122	SB008	drape, sterile, c-arm, fluoro	4.723	item		1		1				1	
123	SD269	Grounding pad	2.5925	item				0		1		1	
124	SB012	drape, sterile, for Mayo stand	1.5335	item				1				1	
125	SC029	needle, 18-27g	0.0767	item		1		1				1	
126	SC051	syringe 10-12ml	0.1905	item		1		2		1		2	
127	SH047	lidocaine 1%-2% inj (Xylocaine)	0.0413	ml				10				10	
128	SD050	electrode needle, injectable (Myoject)	21.2725	item								1	
129	SD087	guide, needle, for localization	13.385	item				1		1		1	
130	SD011	cannula (radiofrequency denervation) (SMK-C10)	24.8075	item						1		4	
131	SC028	needle, 18-26g 1.5-3.5in, spinal	4.9755	item				3					
132	SC055	syringe 3ml	0.1345	item						1			
133	SC057	syringe 5-6ml	0.145	item				0				0	
134	SH021	bupivacaine 0.25% inj (Marcaine)	0.3155	ml		1		5				5	
135	SH022	bupivacaine 0.5% inj (Marcaine)	0.11	ml		1		5		1		5	
136	SJ001	alcohol isopropyl 70%	0.009	ml				5				5	
137	SG021	bandage, strip 0.75in x 3in (Bandaid)	0.1347	item				3				3	
138	SG055	gauze, sterile 4in x 4in	0.167	item									
139	SG056	gauze, sterile 4in x 4in (10 pack uou)	0.899	item				1				1	
140	SL259	Bleach cleaning wipe	0.8775	item				2				2	
141		*Other supply item: please include the name of the item consistent with the paid invoice here and type new in column A*											
143	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**								

	A	B	D	E	F	G	H	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**		**REFERENCE CODE**		**RECOMMENDED**	
2		***Please see brief summaries of the standards/guidelines in column C. For more complete information about summaries and guidelines please see the PE reference materials at the RUC Collaboration Website at the link in the cell below. *Please do not modify formulas in gray shaded cells *Total dollar amounts are included to indicate whether or not compelling evidence is needed and are not direct indicators of an increase or decrease in PE RVU or payment.***				**64493**		**64451**		**64633**		**64625**	
3		***RUC Collaboration Website***				Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level		Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)		Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint		Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)	
4	**Clinical Activity Code**	**Meeting Date: January 2019 Tab: 8: RFA Neurotomy Sacroiliac Joint Specialty: ASA, AAPMR, AAPM, ASIPP, SIS, NANS, NASS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**								
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**											
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 61.74**	**$ 8.88**	**$ 95.03**	**$ 4.07**	**$ 93.50**	**$ 21.41**	**$ 251.70**	**$ 17.57**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**67.0**	**24.0**	**68.0**	**11.0**	**106.0**	**57.0**	**134.0**	**47.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**11.0**	**21.0**	**5.0**	**11.0**	**11.0**	**21.0**	**5.0**	**11.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**53.0**	**0.0**	**63.0**	**0.0**	**59.0**	**0.0**	**93.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**0.0**	**0.0**	**36.0**	**36.0**	**36.0**	**36.0**
144		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 31.53**	**$ -**	**$ 14.10**	**$ -**	**$ 8.34**	**$ 0.32**	**$ 36.56**	**$ 0.18**
145	ED031	printer, dye sublimation (photo, color)	7360.4182	Default	0.029163421	19		0		38			
146	ED032	printer, laser, paper	1152.8125	Default	0.004567669	19		0				0	
147	ED050	Technologist PACS workstation	5557	Default	0.022017924	19		36				51	
148	EF018	stretcher	3460.01	Default	0.009181908	40				59			
149	EF024	table, fluoroscopy	227650.733	Default	0.46429447			0				0	
150	EF031	table, power	6091.913		0.016166271			36				51	
151	EF023	table, exam	2188.0593	Office Visits	0.004867106					36	36	0	36.0
152	EL018	room, mobile c-ARM	151200	Highly Technical	0.572899695	53		22				37	
153	EQ211	pulse oximeter w-printer	1424.36		0.00459731					38			
154	EQ354	radiofrequency kit for destruction by neurolytic agent	2695	Default	0.040425					38		164	0.0
155	EQ168	light, exam	1530.8117	Default	0.004062356			36		36	36	51	
156	ED050	Technologist PACS workstation	5557	PACS	0.022017924	53		0		59		0	
157	EQ214	radiofrequency generator (NEURO)	34018.25	Default	0.131825045					38		51	
158	EQ184	nerve stimulator (eg, for nerve block)	572.3	Default	0.001847174							0	
159	EF015	mayo stand	528.771	Default	0.001176195			36				51	
160	EQ011	ECG, 3-channel (with SpO2, NIBP, temp, resp)	4026.625	Other	0.012996464			56				71	
161		*Other equipment item: please include the name of the item consistent with the paid invoice here and type new in column A*											

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2021

Transcutaneous Passive Implant-Temporal Bone – Tab 6

In October 2020, the CPT Editorial Panel revised two codes to replace "temporal bone" with "skull" and delete "or transcutaneous" and "cochlear stimulator: without mastoidectomy" from the descriptors. The Panel also replaced two codes for mastoidectomy with new codes for magnetic transcutaneous attachment to external speech processor. Additional revisions and codes were added to differentiate implantation, removal, and replacement of the implants.

At the January 2021 RUC meeting, the RUC reviewed these services and determined that they needed to be resurveyed for the April 2021 RUC meeting with a revised Reference Service List (RSL) to encompass a larger range of relative values, specifically to include the lower end of the RVU spectrum. The specialty society submitted a letter to the RUC requesting that this service be referred to the CPT Editorial Panel in May 2021 to clarify the percutaneous implant removal by describing the procedure as removal of the entire implant and adding a parenthetical.

At the April 2021 RUC meeting, the RUC recommended temporarily affirming the January 2021 interim RUC recommendations for work and practice expense inputs for CPT codes 69714, 69716, 69717, 69719, 69726, and 69727 and resurveying these codes for the October 2021 RUC meeting following revisions at the May 2021 CPT Editorial Panel meeting. In May 2021, for CPT 2023, the CPT Editorial Panel established three new codes 69XX0, 69XX1, 69XX2 and added a parenthetical note reporting transcutaneous, passive bone anchored implants for bone conduction hearing appliances.

The specialty society surveyed the codes for the October 2021 RUC meeting as planned. However, prior to the meeting, AMA staff discovered that one of the surveyed codes was listed on the RSL and was selected as the top Key Reference Service (KRS) code for every surveyed code. After discussion at the September 2021 pre-facilitation meeting, the specialty society indicated, and the RUC agreed, that the survey results were invalid and that the codes should be resurveyed for the January 2022 RUC meeting with a revised RSL that has been vetted and approved by the Research Subcommittee.

The RUC recommends that CPT codes 69714, 69716, 69717, 69719, 69726, 69727, 69XX0, 69XX1, and 69XX2 be resurveyed for January 2022, and that the specialty society work with the Research Subcommittee to draft a valid survey.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Auditory System** **Middle Ear** ***Osseointegrated Implants*** *The following codes are for implantation of an osseointegrated implant into the skull. These devices treat hearing loss through surgical placement of an abutment or device into the skull that facilitates transduction of acoustic energy to be received by the better-hearing inner ear or both inner ears when the implant is coupled to a speech processor and vibratory element. This coupling may occur in a percutaneous or a transcutaneous fashion. Other reparative middle ear and mastoid procedures (69501-69676) may be performed for different indications and may be reported separately when performed.*				
▲69714	N1	Implantation, osseointegrated implant, ~~temporal bone~~skull~~, with percutaneous attachment to external speech processor/cochlear stimulator~~; ~~without mastoidectomy~~with percutaneous attachment to external speech processor	090	Resurvey for January 2022 (Interim January 2021 RUC Recommendation = 8.69)
69715	-	~~*with mastoidectomy*~~ (69715 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)	090	~~N/A~~
▲69716	N2	with magnetic transcutaneous attachment to external speech processor within the mastoid and/or resulting in removal of less than 100 mm^2 surface area of bone deep to the outer cranial cortex	090	Resurvey for January 2022 (Interim January 2021 RUC Recommendation = 9.77)
●69XX0	N3	with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 mm^2 surface area of bone deep to the outer cranial cortex	~~090~~	Resurvey for January 2022

▲69717	N4	*Revision/r~~R~~eplacement (including removal of existing device), osseointegrated implant, ~~temporal bone~~skull~~, with percutaneous attachment to external speech processor/cochlear stimulator~~; with percutaneous attachment to external speech processor~~without mastoidectomy~~*	090	Resurvey for January 2022 (Interim January 2021 RUC Recommendation = 8.80)
~~69718~~	-	~~with mastoidectomy~~ (69718 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision/replacement, or removal, see 69501-69676)	~~090~~	~~N/A~~
▲69719	N5	*with magnetic transcutaneous attachment to external speech processor*, within the mastoid and/or involving a bony defect less than 100 mm^2 surface area of bone deep to the outer cranial cortex	090	Resurvey for January 2022 (Interim January 2021 RUC Recommendation = 9.77)
●69XX1	N6	with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 mm^2 surface area of bone deep to the outer cranial cortex	090	Resurvey for January 2022
▲69726	N7	*Removal,* entire *osseointegrated implant, skull; with percutaneous attachment to external speech processor* (To report partial removal of the device [ie, abutment only], use appropriate evaluation and management code)	090	Resurvey for January 2022 (Interim January 2021 RUC Recommendation = 5.93)
▲69727	N8	*with magnetic transcutaneous attachment to external speech processor*, within the mastoid and/or involving a bony defect less than 100 mm^2 surface area of bone deep to the outer cranial cortex	090	Resurvey for January 2022 (Interim January 2021 RUC Recommendation = 7.13)
●69XX2	N9	with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 mm^2 surface area of bone deep to the outer cranial cortex	090	Resurvey for January 2022

AMERICAN ACADEMY OF
OTOLARYNGOLOGY-
HEAD AND NECK SURGERY®

October 4, 2021

Ezequiel Silva III, MD
Chair, Relative Value Scale Update Committee (RUC)
American Medical Association
AMA Plaza
330 N. Wabash Ave., Suite 39300
Chicago, IL 60611-5885

RE: Request to Resurvey Tab 6, Transcutaneous Passive Implant – Temporal Bone family of codes (CPT 69714, 69717, 69X50, 69X51, 69X52, and 69X53) for the January 2022 RUC Meeting

Dear Dr. Silva,

On behalf of the American Academy of Otolaryngology - Head and Neck Surgery (AAO-HNS), we would like to respectfully request permission to resurvey the Transcutaneous Passive Implant – Temporal Bone family of codes (CPT 69714, 69716, 69717, 69719, 69726, 69727, and 69XX0-X2) for the January 2022 RUC meeting.

As you know, these codes were surveyed and presented to the RUC for valuation at the January 2021 meeting. After a lengthy facilitation meeting, it was determined that there was an issue with the survey responses for at least one code in the family, due to resulting rank order anomalies in intra-service time. In response, the RUC assigned interim values for the codes, and requested that the family be resurveyed for the April 2021 RUC meeting. In preparation for our resurvey of this revised family, we worked diligently to incorporate all the feedback from the January 2021 review. Namely, to add in RSL codes the facilitation committee felt were more appropriate, to only include Otolaryngology procedures that were RUC reviewed (even in cases where that created larger gaps in the RSL work values, or where the RUC reviews were done quite some time ago), and to include a much broader span of values, starting with the 5 RVU range and extending up into the 16 RVU range (another request of our facilitation committee). This required a repull of all available reference codes from the RUC database. Regrettably, one of our survey codes, 69714, was captured within the parameters during that repull, and was not flagged for removal during any of our six rounds of internal review. Additionally, it was not flagged after submission of survey materials by the AMA.

Upon review of our survey responses this error was identified. Our society immediately contacted AMA staff and discussed the best options moving forward. It was agreed that our specialty should flag the issue at the onset of review by the RUC and proceed with presentation of our survey for this large family of codes. During prefacilitation, however, reviewers provided feedback that they felt this error rendered the survey

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results “unusable” and directed the Academy to resurvey for the January 2022 cycle, since it remains within the same cycle as the October 2021 meeting.

Based on this feedback, we present this letter to the RUC panel and respectfully request permission to resurvey for the January 2022 meeting. We additionally plan to submit this tab for the October 19th Research Subcommittee meeting, for review of our January 2022 Reference Service List, to ensure all parties are comfortable with the comparator codes provided to survey respondents.

Thank you in advance for your consideration of this request. If you have any questions, please contact Jenna Minton, AAO-HNS RUC staff, at jenna@proactivestrategies.net or 517.927.8696.

Sincerely,

R. Peter Manes, MD
AAO-HNS RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2021

Pulmonary Angiography – Tab 8

In May 2021, the CPT Editorial Panel revised CPT code 93568 to include "nonselective" and "arterial" in its long descriptor and created four new Category I CPT Codes to report injection procedure during cardiac catheterization including imaging supervision, interpretation, and reporting for selective pulmonary arterial angiograph (unilateral and bilateral) and for selective pulmonary angiography of each distinct pulmonary vein and from an arterial approach. CPT add-on codes 93563-93567 were surveyed as part of the same code family for the October 2021 RUC meeting.

Compelling Evidence

The RUC reviewed and agreed that there is compelling evidence based on a change in the patient population, prior incorrect assumptions, and a change in technology/technique. The specialty noted that pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. The prior version of CPT code 93568, with the long descriptor stating *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure),* was created to describe pulmonary angiography with congenital, as well as non-congenital cardiac catheterization. It does not distinguish between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code does not capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient.

Incorrect Assumptions The prior survey for 93568 included only traditional interventional cardiologists and had a vignette that was not explicitly for a pediatric patient. No pediatric/congenital interventional cardiologists were explicitly included in the prior survey even though the typical patient for selective pulmonary angiography is a pediatric patient. These services are predominantly performed by physicians who were not included in the prior survey.

Change in Technique Complex angiographic techniques have been performed for decades to delineate the pulmonary anatomy yet only a single general pulmonary angiography code was available to capture the work of both non-selective and selective pulmonary angiography. Pulmonary veins and Major Aortopulmonary Collateral Arteries (MAPCAs) were not considered when 93568 was created. For example, the submitted article by Soquet, et al. describes the change in management of pulmonary atresia with ventricular septal defect that require information gleaned by pulmonary angiography, and Adamson, et al. articulate the complexity of managing patients with tetralogy of Fallot and MAPCAs. Additionally, Cory, et al. chronicle the evolution of techniques used to treat pediatric pulmonary vein stenosis.

Change in Patient Population The specialty societies noted, and the RUC agreed, that diagnostic catheter studies were performed in children who were relatively healthier with simpler cardiac defects when the previous code structure was last valued a decade ago; children with more significant cardiac defects had fewer treatment options. As result of improvements in both technique and technology, the specialty has evolved, and the typical patient is now more complex.

The RUC concurred that there is compelling evidence that the physician work for these services has changed due to prior incorrect assumptions, change in technology/technique and a change in patient population.

93563 ***Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 1.11 for CPT code 93563, below the survey 25th percentile. The RUC recommends 15 minutes of intra-service and total time for this add-on service.

The RUC noted that when this service was last reviewed in 2010, the RUC recommended 2.00 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at that time. CMS implemented a work value that was only slightly more than half the value of the RUC recommendation based on an arbitrary calculation; the recommended physician time was implemented as well. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 1.11, the RUC compared the surveyed code to the second key reference code 93571 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)* (work RVU= 1.38, intra-service and total time of 15 minutes) and noted that both services involve an identical amount of time. The RUC also compared the surveyed code to MPC code 64480 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.20, intra-service and total time of 15 minutes) and noted that both services involve an identical amount of time and involve a similar amount of physician work. The RUC's recommendation assigns this service a physician work intensity that is below both key reference services. **The RUC recommends a work RVU of 1.11 for CPT code 93563.**

93564 ***Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 25 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 1.13 for CPT code 93564, below the survey 25th percentile. CPT code 93564 did not reach the 30-survey response threshold and will be re-reviewed in three years by the Relativity Assessment Workgroup. At that time, specialty societies will submit an action plan indicating whether this service should either be resurveyed or referred to the CPT Editorial Panel for subsequent deletion or revision to a Category III code. The RUC recommends 18 minutes of intra-service and total time for this add-on service.

The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 2.10 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was only slightly more than half the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 1.13, the RUC compared the surveyed code to the second key reference code 93571 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)* (work RVU= 1.38, intra-service and total time of 15 minutes) and noted that the surveyed code involves somewhat more time to perform. The RUC also compared the surveyed code to MPC code 64480 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.20, intra-service and total time of 15 minutes) and noted that the surveyed code involves more time, though both services involve a similar amount of physician work. The RUC's recommendation assigns this service a physician work intensity that is below both key reference services. **The RUC recommends a work RVU of 1.13 for CPT code 93564.**

93565 ***Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 0.86 for CPT code 93565, below the survey 25th percentile. The RUC recommends 10 minutes of intra-service and total time for this add-on service.

The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 1.90 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was only slightly more than half the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 0.86, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that both services involve an identical amount of time, whereas the reference code is a slightly more intense service. The RUC also compared the surveyed code to CPT code 93572 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-

service and total time of 11 minutes) and noted that with one less minute of intra-service time, the surveyed code is appropriately valued somewhat lower than this reference code which has a similar work intensity. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 0.86 for CPT code 93565.**

93566 ***Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 34 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 0.86 for CPT code 93566, below the survey 25th percentile. The RUC recommends 10 minutes of intra-service and total time for this add-on service.

The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 0.96 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUs for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was lower than the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 0.86, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that both services involve an identical amount of time, whereas the reference code is a slightly more intense service. The RUC also compared the surveyed code to CPT code 93572 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 11 minutes) and noted that with one less minute of intra-service time, the surveyed code is appropriately valued somewhat lower than this reference code which has a similar work intensity. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 0.86 for CPT code 93566.**

93567 ***Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 34 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 0.97 for CPT code 93567, below the survey 25th percentile. The RUC recommends 10 minutes of intra-service and total time for this add-on service.

The specialties noted that, relative to CPT codes 93565 and 93566 which also typically involve 10 minutes of time, 93567 is a more intense service to perform. CPT code 93567 is typically provided to a relatively sicker and older adult population compared to codes 93565 and 93566, due to there being a greater risk of rupture and catheter passes are more tortuous in the senior population. There is a higher likelihood of a calcified

aorta and risk for the dislocation of aortic plaque. Finally, when working in the aorta, extra care must be taken to avoid the iatrogenic introduction of air into the vasculature.

To justify a value of 0.97, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that both services involve an identical amount of time, whereas the reference code is a slightly more intense service. The RUC also compared the surveyed code to CPT code 93572 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 11 minutes) and noted that though the surveyed code typically involves one less minute of intra-service time, it is a slightly more intense service to perform; it is warranted to have both services have a similar valuation. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. The RUC concluded that the value of CPT code 93567 should be maintained at 0.97 RVUs as previously accepted by CMS and supported by the current survey. **The RUC recommends a work RVU of 0.97 for CPT code 93567.**

93568 ***Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for nonselective pulmonary arterial angiography (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 35 interventional and pediatric interventional cardiologists and recommends maintaining the current work RVU of 0.88 for CPT code 93568, below the survey 25th percentile. The RUC recommends 13 minutes of intra-service and total time for this add-on service. The CPT Editorial Panel revised CPT code 93568 to include "nonselective" and "arterial" in its long descriptor. It was noted that although the prior version of 93568 did not specifically state "non-selective" or "arterial", the previous surveyed typical patient with dyspnea and echocardiographic findings would most commonly only require non-selective pulmonary arterial angiography.

The RUC noted that when this service was last reviewed in 2010, the RUC had recommended 0.96 work RVUs. CMS did not accept the RUC recommendation and instead applied a 10 percent reduction to the sum of the current work RVUS for the component codes, considering any multiple procedure reduction that would apply under CMS policy at the time. CMS implemented a work value that was lower than the value of the RUC recommendation based on an arbitrary calculation, while at the same time implementing the recommended physician time. CMS' decision in 2010 fully decoupled the relationship between physician work and physician time and assigned the service an inappropriately low physician work intensity. Although the RUC is now proposing to maintain the current value for this service, it is a large reduction from the RUC's previous recommendation.

To justify a value of 0.88, the RUC compared the surveyed code to the second key reference code 93561 *Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)* (work RVU= 0.95, intra-service and total time of 15 minutes) and noted that the surveyed code involves somewhat less time to perform and therefore it would be appropriate to assign it a somewhat lower valuation. The RUC also compared the surveyed code to reference code 15274 *Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)* (work RVU= 0.80, intra-service and total time of 10 minutes) and noted that the surveyed code involves 3 more minutes of total time,

justifying the higher valuation. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 0.88 for CPT code 93568.**

93569 ***Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, unilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 32 interventional and pediatric interventional cardiologists and recommends the survey 25th percentile work RVU of 1.05 for CPT code 93569. The RUC recommends 11 minutes of intra-service and total time for this new add-on service. As specified in the CPT introductory language, selective pulmonary angiography codes for cardiac catheterization (93569, 93573, 93574, 93575)] include selective angiographic catheter positioning, injection, and radiologic supervision and interpretation. The RUC noted that the typical patient for this service is pediatric, whereas the former general code for reporting pulmonary angiography, 93568 was also used for non-selective pulmonary angiography and was last reviewed in 2010 using a non-pediatric typical patient.

To justify a work RVU of 1.05, the RUC compared the surveyed code to MPC code 64484 *Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.00, intra-service and total time of 10 minutes) and noted that the surveyed code involves one more minute of time and should be assigned a slightly higher work value. The RUC also compared the surveyed code to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves less time to perform and less physician work, justifying a lower valuation than the top key reference service. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 1.05 for CPT code 93569.**

93573 ***Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, bilateral (List separately in addition to code for primary procedure)***
The RUC reviewed the survey results from 33 interventional and pediatric interventional cardiologists and recommends the survey 25th percentile work RVU of 1.75 for CPT code 93573. The RUC recommends 18 minutes of intra-service and total time for this new add-on service. As specified in the CPT introductory language, selective pulmonary angiography codes for cardiac catheterization (93569, 93573, 93574, 93575) include selective angiographic catheter positioning, injection, and radiologic supervision and interpretation. The RUC noted that the typical patient for this service is pediatric, whereas the former general code for reporting pulmonary angiography 93568 was also used for non-selective pulmonary angiography and was last reviewed in 2010 using a non-pediatric typical patient.

To justify a work RVU of 1.75, the RUC compared the surveyed code to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves 3 more minutes of total time and is less intense to perform, supporting the proposed value. The RUC also compared the surveyed code to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU=

1.75, intra-service and total time of 20 minutes) and noted that although the surveyed code involves less time, it involves a moderately higher physician work intensity. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 1.75 for CPT code 93573.**

93574 ***Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization. (List separately in addition to code for primary procedure)*** The RUC reviewed the survey results from 32 interventional and pediatric interventional cardiologists and recommends the survey 25th percentile work RVU of 1.84 for CPT code 93574. The RUC recommends 20 minutes of intra-service and total time for this new add-on service. As specified in the CPT introductory language, selective pulmonary angiography codes for cardiac catheterization (93569, 93573, 93574, 93575) include selective angiographic catheter positioning, injection, and radiologic supervision and interpretation. The RUC noted that the typical patient for this service is pediatric, whereas the former general code for reporting pulmonary angiography, 93568 was also used for non-selective pulmonary angiography and was last reviewed in 2010 using a non-pediatric typical patient.

The RUC noted that CPT code 93574 can be reported in multiple units for each distinct pulmonary vein during cardiac catheterization, and that there are typically 4 pulmonary veins, though for some patients it could be 3 or 5 pulmonary veins. The specialty societies noted that each patient would not have angiography performed in all their pulmonary veins, and that typically only veins where the provider has a suspicion from a previous non-invasive study would be studied. The specialty societies also noted that it would be relatively rare to perform this service on 4 or 5 pulmonary veins. In addition, the specialties indicated that the same type of catheter could not be used for multiple pulmonary veins and would need to be switched out for a different shape of catheter or a different wire combination. The specialties noted, and the RUC concurred, that the previous version of code 93568 did not appropriately capture all the time-intensive and relatively intense physician work involved for selective pulmonary venous angiography.

To justify a work RVU of 1.84, the RUC compared the surveyed code to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves 5 more minutes of total time and less intense physician work, supporting the proposed lower value. The RUC also compared the surveyed code to CPT code 36483 *Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)* (work RVU= 1.75, intra-service and total time of 20 minutes) and noted that although both services typically involve an identical amount of time, the surveyed code is a more intense service to perform. The reference service is typically performed on an adult patient and under only local anesthesia, whereas the surveyed code is typically performed on a highly complex pediatric patient. The vignette for 93574, that 100 percent of the survey respondents found to be typical, was: "During a diagnostic cardiac catheterization, a 6-month-old male with down syndrome, status post atrioventricular (av) canal repair with new pulmonary hypertension undergoes multiple selective pulmonary venous angiograms to evaluate for presence of any pulmonary vein stenosis". The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 1.84 for CPT code 93574.**

93575 ***Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, each distinct vessel***
The RUC reviewed the survey results from 33 interventional and pediatric interventional cardiologists and recommends the survey 25th percentile work RVU of 1.92 for CPT code 93575. The RUC recommends 20 minutes of intra-service and total time for this new add-on service. As specified in the CPT introductory language, selective pulmonary angiography codes for cardiac catheterization (93569, 93573, 93574, 93575) include selective angiographic catheter positioning, injection, and radiologic supervision and interpretation. The RUC noted that the typical patient for this service is pediatric, whereas the former general code for reporting pulmonary angiography, 93568 was also used for non-selective pulmonary angiography and was last reviewed in 2010 using a non-pediatric typical patient.

Patients with pulmonary atresia and absent connection often have alternate, non-native, sources of pulmonary blood flow, and it becomes important for the pediatric interventional cardiologist to define those and detail those sources of pulmonary blood flow. Major Aortopulmonary Collateral Arteries (or MAPCAs) are arteries that develop to supply blood to the lungs when native pulmonary circulation is underdeveloped. A patient could have anywhere from only 1 to up to 12 MAPCAs. MAPCAs are tortuous and considerable anatomic variety — they can be small or large at their origin. Selecting different catheters going into and out of each one and getting into them is very time-intensive, complicated and involves intense physician work.

To justify a work RVU of 1.92, the RUC compared the surveyed code to top key reference code 36227 *Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)* (work RVU= 2.09, intra-service and total time of 15 minutes) and noted that the surveyed code involves 5 more minutes of total time and less intense physician work, supporting the proposed lower value. Similarly, 86 percent of the survey respondents that selected 36227 as their top key reference code indicated that the surveyed code is in fact a more intense service to perform. The RUC also compared the surveyed code to MPC code 99292 *Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)* (work RVU= 2.25, 30 minutes of intra-service and total time) and noted that both services would have appropriate relativity with the RUC's recommendation for 93575. The RUC's recommendation assigns this service a physician work intensity between the top and second key reference services. **The RUC recommends a work RVU of 1.92 for CPT code 93575.**

Practice Expense
No direct practice expense inputs are recommended for CPT codes 93563-93568 and 93569-93575 as they are facility-based add-on services.

New Technology/New Service
The RUC recommends that CPT codes 93569, 93573, 93574 and 93575 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

RAW Flag for Service with Less than 30 Survey Responses
CPT code 93564 did not reach the 30-survey response threshold and will be re-reviewed in three years by the Relativity Assessment Workgroup. At that time, specialty societies will submit an action plan indicating whether this service should either be resurveyed or referred to the CPT Editorial Panel for subsequent deletion or revision to a Category III code.

Do Not Use to Validate for Physician Work
The RUC agreed that CPT code 93564 should continue to be labeled in the RUC database with a flag that it should not be used to validate physician work, as the survey for this service did not achieve 30 survey respondents.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Surgery **Cardiovascular System** **Heart and Pericardium** **Implantable Hemodynamic Monitors**				
33289		*Transcatheter implantation of wireless pulmonary artery pressure sensor for long-term hemodynamic monitoring, including deployment and calibration of the sensor, right heart catheterization, selective pulmonary catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed* *(For remote monitoring of an implantable wireless pulmonary artery pressure sensor, use 93264)* (Do not report 33289 in conjunction with 36013, 36014, 36015, 75741, 75743, 75746, 76000, 93451, 93453, 93456, 93457, 93460, 93461, 93530, 93531, 93532, 93533, 93568, 93569, 93573)		
Cardiac Valves **Pulmonary Valve**				
Code 33477 is used to report transcatheter pulmonary valve implantation (TPVI). Code 33477 should only be reported once per session. *Code 33477 includes the work, when performed, of percutaneous access, placing the access sheath, advancing the repair device delivery system into position, repositioning the device as needed, and deploying the device(s). Angiography, radiological supervision, and interpretation performed to guide TPVI (eg, guiding device placement and documenting completion of the intervention) are included in the code.* Code 33477 includes all cardiac catheterization(s), intraprocedural contrast injection(s), fluoroscopic radiological supervision and interpretation, and imaging guidance performed to complete the pulmonary valve procedure. Do not report 33477 in conjunction with 76000, 93451, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, *93593, 93594, 93596, 93597, 93598* ~~*93530, 93531, 93532, 93533*~~, 93563, 93566, 93567, 93568, 93569, 93573 for angiography intrinsic to the procedure.			

Code 33477 includes percutaneous balloon angioplasty of the conduit/treatment zone, valvuloplasty of the pulmonary valve conduit, and stent deployment within the pulmonary conduit or an existing bioprosthetic pulmonary valve, when performed. Do not report 33477 in conjunction with 37236, 37237, 92997, 92998 for pulmonary artery angioplasty/valvuloplasty or stenting within the prosthetic valve delivery site.

Codes 92997, 92998 may be reported separately when pulmonary artery angioplasty is performed at a site separate from the prosthetic valve delivery site. Codes 37236, 37237 may be reported separately when pulmonary artery stenting is performed at a site separate from the prosthetic valve delivery site.

Diagnostic right heart catheterization and diagnostic ~~coronary~~ angiography codes (93451, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93593*, 93594, 93596, 93597, 93598* ~~*93530, 93531, 93532, 93533*~~, 93563, 93566, 93567, 93568, 93569, 93573) should **not** be used with 33477 to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TPVI,

2. Pulmonary conduit angiography for guidance of TPVI, or

3. Right heart catheterization for hemodynamic measurements before, during, and after TPVI for guidance of TPVI.

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, *93593, 93594, 93595, 93596, 93597, 93598* ~~*93530, 93531, 93532, 93533*~~), diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564), and diagnostic pulmonary angiography codes (93568, 93569, 93573, 93574, 93575) may be reported with 33477, representing separate and distinct services from TPVI, if:

1. No prior study is available and a full diagnostic study is performed, or

2. A prior study is available, but as documented in the medical record:

   a. There is inadequate visualization of the anatomy and/or pathology, or

   b. The patient's condition with respect to the clinical indication has changed since the prior study, or

   c. There is a clinical change during the procedure that requires new evaluation.

Other cardiac catheterization services may be reported separately when performed for diagnostic purposes not intrinsic to TPVI.

For same session/same day diagnostic cardiac catheterization services, report the appropriate diagnostic cardiac catheterization code(s) appended with modifier 59 to indicate separate and distinct procedural services from TPVI.

Diagnostic coronary angiography performed at a separate session from an interventional procedure may be separately reportable, when performed.

Percutaneous coronary interventional procedures may be reported separately, when performed.

Percutaneous pulmonary artery branch interventions may be reported separately, when performed.

When transcatheter ventricular support is required in conjunction with TPVI, the appropriate code may be reported with the appropriate percutaneous ventricular assist device (VAD) procedure codes (33990, 33991, 33992, 33993, 33995, 33997), extracorporeal membrane oxygenation (ECMO) or extracorporeal life support services (ECLS) procedure codes (33946-33989), or balloon pump insertion codes (33967, 33970, 33973).

When cardiopulmonary bypass is performed in conjunction with TPVI, code 33477 may be reported with the appropriate add-on code for percutaneous peripheral bypass (33367), open peripheral bypass (33368), or central bypass (33369).

33470 Valvotomy, pulmonary valve, closed heart; transventricular

Shunting Procedures

Codes 33741, 33745 are typically used to report creation of effective intracardiac blood flow in the setting of congenital heart defects. Code 33741 (transcatheter atrial septostomy) involves the percutaneous creation of improved atrial blood flow (eg, balloon/blade method), typically in infants ≤4 kg with congenital heart disease. Code 33745 is typically used for intracardiac shunt creation by stent placement to establish improved intracardiac blood flow (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles). Code 33746 is used to describe each additional intracardiac shunt creation by stent placement at a separate location during the same session as the primary intervention (33745).

Code 33741 includes percutaneous access, placing the access sheath(s), advancement of the transcatheter delivery system, and creation of effective intracardiac atrial blood flow. Codes 33741, 33745 include, when performed, ultrasound guidance for vascular access and fluoroscopic guidance for the intervention. Code 33745 additionally includes intracardiac stent placement, target zone angioplasty preceding or after stent implantation, and complete diagnostic right and left heart catheterization, when performed.

Diagnostic cardiac catheterization is not typically performed at the same session as transcatheter atrial septostomy (33741) and, when performed, may be separately reported. Diagnostic cardiac catheterization is typically performed at the same session with 33745 and the code descriptor includes this work, when performed.

Cardiovascular injection procedures for diagnostic angiography reported using 93563, 93565, 93566, 93567, 93568, 93569, 93573, 93574, 93575 are not typically performed at the same session as 33741. Although diagnostic angiography is typically performed during 33745, target vessels and chambers are highly variable and, when performed~~,~~ for an evaluation separate and distinct from the shunt creation, may be reported separately.

Codes 33745, 33746 are used to describe intracardiac stent placement. Multiple stents placed in a single location may only be reported with a single code. When additional, different intracardiac locations are treated in the same session, 33746 may be reported. Codes 33745, 33746 include ~~any and~~ all balloon angioplasty(ies) performed in the target lesion, including any pre-dilation (whether performed as a primary or secondary dilation), post-dilation following stent placement, or use of larger/smaller balloon to achieve therapeutic result. Angioplasty in a separate and distinct intracardiac lesion may be reported separately. Use 33746 in conjunction with 33745.

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, *93593, 93594, 93595, 93596, 93597, 93598* ~~*93530, 93531, 93532, 93533*~~) should not be used in conjunction with 33741, 33745 to report:

1. Fluoroscopic guidance for the intervention, or

2. Limited hemodynamic and angiographic data used solely for purposes of accomplishing the intervention (eg, measurement of atrial pressures before and after septostomy, atrial injections to determine appropriate catheter position)

Diagnostic ~~congenital~~ right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, *93593, 93594, 93595, 93596, 93597, 93598* ~~*93530, 93531, 93532, 93533*~~) performed at the same session as 33741, may be separately reported, if:

1. No prior study is available, and a full diagnostic study is performed, or

2. A prior study is available, but as documented in the medical record:

a. There is inadequate visualization of the anatomy and/or pathology, or

b. The patient's condition with respect to the clinical indication has changed since the prior study, or

c. There is a clinical change during the procedure that requires a more thorough evaluation.

~~For same-session diagnostic congenital catheterization services, the appropriate diagnostic cardiac catheterization code(s) for congenital anomalies (*93593, 93594, 93595, 93596, 93597, 93598* *93530, 93531, 93532, 93533*) may be reported by appending modifier 59, indicating separate and distinct procedural service(s) from 33741.~~ For same-session diagnostic cardiac angiography for an evaluation separate and distinct from 33741 or 33745 ~~the shunt creation~~, the appropriate contrast injection(s) performed (93563, 93565, 93566, 93567, 93568, 93569, 93573, 93574, 93575) may be reported ~~by appending modifier 59, indicating separate and distinct procedural service(s) from 33741, 33745~~.

33735 *Atrial septectomy or septostomy; closed heart (Blalock-Hanlon type operation)*

Arteries and Veins
Vascular Injection Procedures

Listed services for injection procedures include necessary local anesthesia, introduction of needles or catheter, injection of contrast media with or without automatic power injection, and/or necessary pre- and postinjection care specifically related to the injection procedure.

Selective vascular catheterization should be coded to include introduction and all lesser order selective catheterization used in the approach (eg, the description for a selective right middle cerebral artery catheterization includes the introduction and placement catheterization of the right common and internal carotid arteries).

Additional second and/or third order arterial catheterization within the same family of arteries or veins supplied by a single first order vessel should be expressed by 36012, 36218, or 36248.

Additional first order or higher catheterization in vascular families supplied by a first order vessel different from a previously selected and coded family should be separately coded using the conventions described above.

*(For radiological supervision and interpretation, see **Radiology**)*

(For injection procedures in conjunction with cardiac catheterization, see 93452-93461, 93563-93568, 93569, 93573, 93574, 93575)

(For chemotherapy of malignant disease, see 96401-96549)

Intravenous

An intracatheter is a sheathed combination of needle and short catheter.

36000 Introduction of needle or intracatheter, vein

Radiology
Diagnostic Radiology (Diagnostic Imaging)
Vascular Procedures
Aorta and Arteries

75743 Angiography, pulmonary, bilateral, selective, radiological supervision and interpretation

(For selective pulmonary arterial angiography during cardiac catheterization see 93569, 93573)

(For selective pulmonary venous angiography during cardiac catheterization, each distinct vein, use 93574)

(For selective pulmonary angiography of major aortopulmonary collateral arteries [MAPCAs] arising off the aorta or its systemic branches use 93575)

75746 Angiography, pulmonary, by nonselective catheter or venous injection, radiological supervision and interpretation

(For nonselective pulmonary arterial angiography by ~~nonselective~~ catheter ~~or venous~~ injection performed at the time of cardiac catheterization, use 93568, which includes imaging supervision, interpretation, and report)

+75774 Angiography, selective, each additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure)

(For cardiac catheterization procedures, see 93452-93462, *93593, 93594, 93595, 93596, 93597*~~*93531-93533*~~, 93563-93568, 93569, 93573, 93574, 93575)

(For radiological supervision and interpretation of dialysis circuit angiography performed through existing access[es] or catheter-based arterial access, use 36901 with modifier 52)

Medicine
Cardiovascular
Cardiac Catheterization

Cardiac catheterization is a diagnostic medical procedure which includes introduction, positioning and repositioning, when necessary, of catheter(s), within the vascular system, recording of intracardiac and/or intravascular pressure(s), and final evaluation and report of procedure. There are two code families for cardiac catheterization: one for congenital heart disease and one for all other conditions. *For cardiac*

catherization for congenital heart defects (93593, 93594, 93595, 93596, 93597, 93598), see the ***Medicine/Cardiovascular/Cardiac Catheterization for Congenital Heart Defects*** *subsection. The following guidelines apply to cardiac catheterization performed for indications other than the evaluation of congenital heart defects. ~~Anomalous coronary arteries, patent foramen ovale, mitral valve prolapse, and bicuspid aortic valve are to be reported with 93451-93464, 93566-93568.~~*

Right ~~h~~Heart ~~c~~Catheterization: *for indications other than the evaluation of congenital heart defects (93453, 93456, 93457, 93460, 93461)* includes catheter placement in one or more right-sided cardiac chamber(s) or structures (ie, the right atrium, right ventricle, pulmonary artery, pulmonary wedge), obtaining blood samples for measurement of blood gases, and cardiac output measurements (Fick or other method), when performed. For placement of a flow directed catheter (eg, Swan-Ganz) performed for hemodynamic monitoring purposes not in conjunction with other catheterization services, use 93503. *Do not report 93503 in conjunction with other diagnostic cardiac catheterization codes.* Right heart catheterization does not include right ventricular or right atrial angiography (93566). ~~*Left heart catheterization involves catheter placement in a left-sided (systemic) cardiac chamber(s) (left ventricle or left atrium) and included left ventricular injection(s) when performed. Do not report 93503 in conjunction with other diagnostic cardiac catheterization codes. When right heart catheterization is performed in conjunction with other cardiac catheterization services, report 93453, 93456, 93457, 93460, or 93461.*~~

For right heart catheterization as part of catheterization to evaluate congenital heart defects, see 93593, 93594, 93596, 93597, 93598. For reporting purposes, when the morphologic left ventricle is in a subpulmonic position (eg, certain cases of transposition of the great arteries) due to congenital heart disease, catheter placement with hemodynamic assessment in this structure during right heart catheterization is considered part of that procedure, and does not constitute left heart catheterization. When the subpulmonic ventricle also connects to the aorta (eg, double outlet right ventricle), catheter placement with hemodynamic assessment of this ventricle during right heart catheterization is considered part of that procedure, while catheter placement with hemodynamic assessment of that same ventricle from the arterial approach is considered left heart catheterization. Report the appropriate code for right and left heart catheterization if catheter placement with hemodynamic assessment of the double outlet ventricle is performed both during the right heart catheterization and separately from the arterial approach. Right heart catheterization for congenital heart defects does not typically involve thermodilution cardiac output assessments. When thermodilution cardiac output is performed in this setting it may be separately reported using 93598). ~~*When left heart catheterization is performed using either transapical puncture of the left ventricle or transseptal puncture of an intact septum, report 93462 in conjunction with 93452, 93453, 93458-93461, 93653, 93654. Catheter placement(s) in coronary artery(ies) involves selective engagement of the origins of the native coronary artery(ies) for the purpose of coronary angiography. Catheter placement(s) in bypass graft(s) (venous, internal mammary, free arterial graft[s]) involve selective engagement of the origins of the graft(s) for the purpose of bypass angiography. It is typically performed only in conjunction with coronary angiography of native vessels.*~~

Left Heart Catheterization: *for indications other than congenital heart defects (93452, 93453, 93458, 93459, 93460, 93461) involves catheter placement in a left-sided (systemic) cardiac chamber(s) (left ventricle or left atrium) and includes left ventricular/left atrial angiography, imaging supervision, and interpretation, when performed. For reporting purposes, when the morphologic right ventricle is in a systemic (subaortic) position due to congenital heart disease (eg, certain cases of transposition of the great arteries), catheter placement with hemodynamic assessment of the subaortic ventricle performed during left heart catheterization is considered part of the procedures and does not constitute right heart catheterization. If additional catheterization of right heart structures (eg, atrium, pulmonary artery) is performed at the same setting, report the appropriate code for right and left heart catheterization. When left heart catheterization is performed using either*

transapical puncture of the left ventricle or transseptal puncture of an intact septum, report 93462 in conjunction with 93452, 93453, 93458-93461, 93596, 93597. For left heart catheterization services for the evaluation of congenital heart defects, see 93595, 93596, 93597, 93565.

Catheter Placement and Injection Procedures: *For a listing of the injection procedures included in specific cardiac catheterization procedures, please refer to the tables on pages (X-X).*

Cardiac catheterization (93451-93461), other than for the evaluation of congenital heart defects, includes: a) all roadmapping angiography in order to place the catheters; b) any injections for angiography of the left ventricle, left atrium, native coronary arteries or bypass grafts listed as inherent to the procedure in the cardiac catheterization table located on pages X-X; and c) imaging supervision, interpretation, and report. Do not report 93563, 93464, 93565 in conjunction with 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461. The cardiac catheterization codes do not include contrast injection(s) and imaging supervision, interpretation, and report for imaging that is separately identified by other specific procedure code(s).

Catheter placement(s) in coronary artery(ies) involves selective engagement of the origins of the native coronary artery(ies) for the purpose of coronary angiography. Catheter placement(s) in bypass graft(s) (venous, internal mammary, free arterial graft[s]) involves selective engagement of the origins of the graft(s) for the purpose of bypass angiography. Bypass graft angiography is typically performed only in conjunction with coronary angiography of native vessels.

~~*The cardiac catheterization codes (93452-93461), other than those for congenital heart disease, include contrast injection(s), imaging supervision, interpretation, and report for imaging typically performed. Codes for left heart catheterization (93452, 93453, 93458-93461), other than those for congenital heart disease, include intraprocedural injection(s) for left ventricular/left atrial angiography, imaging supervision, and interpretation, when performed.*~~ Codes for ~~*coronary*~~ catheter placement(s) *in native coronary arteries* (93454-93461) *and bypass graft(s) (93455, 93457, 93459, 93461)* ~~*, other than those for congenital heart disease,*~~ include intraprocedural injection(s) for coronary*/bypass graft* angiography, imaging supervision, and interpretation*, except when these catheter placements are performed during cardiac catheterization for the evaluation of congenital heart defects.* ~~*Codes for catheter placement(s) in bypass graft(s) (93455, 93457, 93459, 93461), other than those for congenital heart disease, include intraprocedural injection(s) for bypass graft angiography, imaging supervision, and interpretation.*~~ Do not report 93563-93565 in conjunction with 93452-93461.

For right ventricular or right atrial angiography performed in conjunction with right heart catheterization for noncongenital heart disease (93451, 93453, 93456, 93457, 93460, 93461) or for the evaluation of congenital heart defects (93593, 93594, 93596, 93597), use 93566. For reporting purposes, angiography of the morphologic right ventricle or morphologic right atrium is reported with 93566, whether these structures are in the standard prepulmonic position or in a systemic (subaortic) position. Left heart catheterization performed for noncongenital heart disease (93452, 93453, 93458, 93459, 93460, 93461) includes left ventriculography, when performed. For reporting purposes, angiography of the morphologic left ventricle or morphologic left atrium is reported with 93565, whether these structures are in the standard systemic (subaortic) position or in a prepulmonic position. Do not report 93565 with 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461. For cardiac catheterization performed for the evaluation of congenital heart defects, left ventriculography is separately reported with 93565. For cardiac catheterization for *both congenital and noncongenital* heart defects ~~*cardiac catheterization*~~*, supravalvular aortography is reported with 93567. For* cardiac catheterization for *both congenital and noncongenital* heart defects ~~*cardiac*~~

~~catheterization~~, ~~nonselective~~ *pulmonary* arterial *angiography* or selective pulmonary venous angiography *is reported with* the appropriate pulmonary angiography code(s) (*93568,* 93569, 93573, 93574, 93575) *plus the appropriate* ~~right heart~~ cardiac *catheterization code.*

When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital heart *disease (*~~93451, 93453, 93456, 93457, 93460, 93461,~~ *93593, 93594, 93595, 93596, 93597), see 93563, 93564, 93565, 93566, 93567, 93568,* 93569, 93573, 93574, 93575. *Injection procedures 93563, 93564, 93565, 93566, 93567, 93568,* 93569, 93573, 93574, 93575 *represent separate identifiable services and may be reported in conjunction with one another when appropriate. Codes 93563, 93564, 93565, 93566, 93567, 93568,* 93569, 93573,93574, 93575 *include imaging supervision, interpretation, and report.*

For angiography of noncoronary and nonpulmonary *arteries and veins, performed as a distinct service, use appropriate codes from the Radiology section and the Vascular Injection Procedures section.*

~~*For cardiac catheterization for congenital cardiac anomalies, see 93530-93533. When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital anomalies, see 93563-93568*~~

~~*Cardiac catheterization (93451-93461) includes all roadmapping angiography in order to place the catheters, including any injections and imaging supervision, interpretation, and report. It does not include contrast injection(s) and imaging supervision, interpretation, and report for imaging that is separately identified by other specific procedure code(s). For right ventricular or right atrial angiography performed in conjunction with cardiac catheterization for congenital or noncongenital heart disease (93451-93461, 93530-93533), use 93566. For aortography, use 93567. For pulmonary angiography, use 93568. For angiography of noncoronary arteries and veins, performed as a distinct service, use appropriate codes from the Radiology section and the Vascular Injection Procedures section.*~~

For nonselective pulmonary arterial angiography, use 93568. For selective unilateral or bilateral pulmonary arterial angiography, see 93569, 93573. For selective pulmonary venous angiography, use 93574 for each distinct vessel. For selective pulmonary arterial angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, use 93575 for each distinct vessel.

Injection procedures 93574, 93575 represent selective venous and arterial angiography, respectively, for each distinct vessel. Codes 93574, 93575 require evaluation of a distinct named vessel (eg, right upper pulmonary vein, left lower pulmonary vein, left pulmonary artery via Blalock-Taussig [BT] shunt access, major aortopulmonary collateral artery [MAPCA] vessel #1 from underside of aortic arch) and may be reported for each distinct named vessel evaluated.

Selective pulmonary angiography codes for cardiac catheterization [93569, 93573, 93574, 93575], include selective angiographic catheter positioning, injection, and radiologic supervision and interpretation)

Adjunctive Hemodynamic Assessments: ~~*W*~~*w*hen cardiac catheterization is combined with pharmacologic agent administration with the specific purpose of repeating hemodynamic measurements to evaluate hemodynamic response, use 93463 in conjunction with 93451-93453, 93456-93461*, 93593, 93594, 93595, 93596, 93597*. Do not report 93463 for intracoronary administration of pharmacologic agents during percutaneous coronary interventional procedures, during intracoronary assessment of coronary pressure, flow or resistance, or during intracoronary imaging procedures. Do not report 93463 in conjunction with 92920-92944, 92975, 92977.

When cardiac catheterization is combined with exercise (eg, walking or arm or leg ergometry protocol) with the specific purpose of repeating hemodynamic measurements to evaluate hemodynamic response, report 93464 in conjunction with 93451-93453, 93456-93461, ~~and~~93593, 93594, 93595, 93596, 93597~~93530-93533~~.

Contrast injection to image the access site(s) for the specific purpose of placing a closure device is inherent to the catheterization procedure and not separately reportable. Closure device placement at the vascular access site is inherent to the catheterization procedure and not separately reportable.

~~*Please see the cardiac catheterization table located on page 684.*~~

93451 Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed

~~***Injection Procedures***~~

~~*All injection codes include radiological supervision, interpretation, and report. Cardiac catheterization codes (93452-93461), other than those for congenital heart disease, include contrast injection(s) for imaging typically performed during these (see Cardiac Catheterization above). Do not report 93563-93565 in conjunction with 93452-93461. When injection procedures for right ventricular, right atrial, aortic, or pulmonary angiography are performed in conjunction with cardiac catheterization, these services are reported separately (93566-93568). When right ventricular or right atrial angiography is performed at the time of heart catheterization, use 93566 with the appropriate catheterization code (93451, 93453, 93456, 93457, 93460, or 93461. Use 93567 when supravalvular ascending aortography is performed at the time of heart catheterization. Use 93568 with the appropriate right heart catheterization code when pulmonary angiography is performed. Separately reported injection procedures do not include introduction of catheters but do include repositioning of catheters when necessary and use of automatic power injectors, when performed.*~~

~~*When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital cardiac anomalies (93530-93533), see 93563-93568. Injection procedure codes 93563-93568 include imaging supervision, interpretation, and report.*~~

~~*Injection procedures 93563-93568 represent separate identifiable services and may be coded in conjunction with one another when appropriate. The technical details of angiography, supervision of imaging and processing, interpretation, and report are included.*~~

~~Injection procedures 93574, 93575 represent selective venous and arterial angiography, respectively, for each distinct vessel. Codes 93574, 93575 require of a distinct named vessel for each location (eg, right upper pulmonary vein, left lower pulmonary vein, left pulmonary artery via Blalock-Taussig [BT] shunt access, major aortopulmonary collateral artery [MAPCA] vessel #1 from underside of aortic arch).~~

~~*93561 Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)*~~

~~*93562 subsequent measurement of cardiac output*~~

~~*(Do not report 93561, 93562 in conjunction with 93451-93462, 93582)*~~

(Codes 93561, 93562 have been deleted)

(For cardiac output measurement[s], thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects, use 93598) *(For radioisotope method of cardiac output, see 78472, 78473, or 78481)*				
(f)✚93563	P1	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)	ZZZ	1.11 (No Change)
(f)✚93564	P2	for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization (List separately in addition to code for primary procedure)	ZZZ	1.13 (No Change)
(Do not report 93563, 93564 in conjunction with 33418, 0345T, 0483T, 0484T, 0544T, 0545T for coronary angiography intrinsic to the valve repair or annulus reconstruction procedure)				
(f)✚*93565*	P3	for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)	ZZZ	0.86 (No Change)
(Do not report 93563-93565 in conjunction with 93452-93461) (Use 93563-93565 in conjunction with *93593, 93594, 93595, 93596, 93597~~93530-93533~~*)				

(f)✚93566	P4	for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure) (Use 93566 in conjunction with 93451, 93453, 93456, 93457, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 9358293530-93533) (Do not report 93566 in conjunction with 33274 for right ventriculography performed during leadless pacemaker insertion) (Do not report 93566 in conjunction with 0545T for right ventricular or right atrial angiography procedures intrinsic to the annulus reconstruction procedure)	ZZZ	0.86 (No Change)
(f)✚93567	P5	for supravalvular aortography (List separately in addition to code for primary procedure) (Use 93567 in conjunction with 93451-93461,93593, 93594, 93595, 93596, 9359793530-93533) (For non-supravalvular thoracic aortography or abdominal aortography performed at the time of cardiac catheterization, use the appropriate radiological supervision and interpretation codes [36221, 75600-75630])	ZZZ	0.97 (No Change)
✚□93568	P6	for nonselective pulmonary arterial angiography (List separately in addition to code for primary procedure) (Use 93568 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, *33894, 33895, 33900, 33901, 33902, 33903, 33904,* 37187, 37188, 37236, 37237, 37238, 37246, 37248, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, *93530-93533, 93593, 93594, 93595, 93596, 93597, 93580, 93581*, 93582, 93583) (For selective unilateral or bilateral pulmonary arterial angiography, use 93569, 93573, which include catheter placement, injection, and radiologic supervision and interpretation)	ZZZ	0.88 (No Change)

✚●93569	P7	for selective pulmonary arterial angiography, unilateral (List separately in addition to code for primary procedure)	ZZZ	1.05
✚●93573	P8	for selective pulmonary arterial angiography, bilateral (List separately in addition to code for primary procedure)	ZZZ	1.75
(Use 93569, 93573 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, ~~33746,~~ 37236, 37237, 37238, 37246, 37248, *33894, 33895, 33900, 33901, 33902, 33903, 33904,* 37187, 37188, 92997,92998,93451, 93453, 93456, 93457, 93460, 93461, *93593, 93594, 93595, 93596, 93597*, 93505, 93580, 93581, 93582, 93583)				
✚●93574	P9	for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization. (List separately in addition to code for primary procedure) (Use 93574 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, 37236, 37237, 37238, 37246, 37248, *33894, 33895, 33900, 33901, 33902, 33903, 33904,* 37187, 37188, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, *93593, 93594, 93595, 93596, 93597,* 93505, 93580, 93581, 93582, 93583)	ZZZ	1.84
✚●93575	P10	for selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, each distinct vessel (Use 93575 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, 37236, 37237, 37238, 37246, 37248, *33894, 33895, 33900, 33901, 33902, 33903, 33904,* 37187, 37188, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, *93593, 93594, 93595, 93596, 93597,* 93505, 93580, 93581, 93582, 93583)	ZZZ	1.92
(93569, 93573, 93574, 93575 include the selective introduction and positioning of the angiographic catheter, injection, and radiologic supervision and interpretation)				

Repair of Structural Heart Defect

93582 *Percutaneous transcatheter closure of patent ductus arteriosus*

(93582 includes congenital right and left heart catheterization, catheter placement in the aorta, and aortic arch angiography, when performed)

(Do not report 93582 in conjunction with 36013, 36014, 36200, 75600, 75605, 93451-93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598~~93530, 93531, 93532, 93533~~, 93567)

(For other cardiac angiographic procedures performed at the time of transcatheter PDA closure, see 93563, 93564, 93565, 93566, 93568, 93569, 93573, 93574, 93575 as appropriate)

~~(For left heart catheterization by transseptal puncture through intact septum or by transapical puncture performed at the time of transcatheter PDA closure, use 93462)~~

(For repair of patent ductus arteriosus by ligation, see 33820, 33822, 33824)

(For intracardiac echocardiographic services performed at the time of transcatheter PDA closure, use 93662. Other echocardiographic services provided by a separate individual are reported using the appropriate echocardiography service codes, 93315, 93316, 93317)

93583 *Percutaneous transcatheter septal reduction therapy (eg, alcohol septal ablation) including temporary pacemaker insertion when performed*

(93583 includes insertion of temporary pacemaker, when performed, and left heart catheterization)

(Do not report 93583 in conjunction with 33210, 93452, 93453, 93458, 93459, 93460, 93461, 93595, 93596, 93597~~93531, 93532, 93533~~, 93565)

(93583 includes left anterior descending coronary angiography for the purpose of roadmapping to guide the intervention. Do not report 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563 for coronary angiography performed during alcohol septal ablation for the purpose of roadmapping, guidance of the intervention, vessel measurement, and completion angiography)

(Diagnostic cardiac catheterization procedures may be separately reportable when no prior catheter-based diagnostic study of the treatment zone is available, the prior diagnostic study is inadequate, or the patient's condition with respect to the clinical indication has changed since the prior study or during the intervention. Use the appropriate codes from 93451, 93454, 93455, 93456, 93457, 93593, 93594, 93598~~93530,~~ 93563, 93564, 93566, 93567, 93568, 93569, 93573, 93574, 93575)

(Do not report 93583 in conjunction with 33210, 33211)

(Do not report 93463 for the injection of alcohol for this procedure)

(For intracardiac echocardiographic services performed at the time of alcohol septal ablation, use 93662)

(Other echocardiographic services provided by a separate physician are reported using the appropriate echocardiography services codes, 93312, 93313, 93314, 93315, 93316, 93317)

(For surgical ventriculomyotomy [-myectomy] for idiopathic hypertrophic subaortic stenosis, use 33416)

Cardiac Catheterization for Congenital Heart Defects

Cardiac catheterization for...

Right Heart Catheterization...

Right heart catheterization...

Normal native connections...

Abnormal native connections...

Left Heart Catheterization...

Catheter Placement and...

For cardiac catheterization...

When contrast injection(s) are performed in conjunction with cardiac catheterization for congenital heart defects, see injection procedure codes 93563, 93564, 93565, 93566, 93567, 93568, 93569, 93573, 93574, 93575, or use appropriate codes from the Radiology section and the Vascular Injection Procedures section. Codes 93563, 93564, 93565, 93566, 93567, 93568 include imaging supervision, interpretation, and report.

Injection procedures 93563, 93564, 93565, 93566, 93567, 93568, 93569, 93573, 93574, 93575 represent separate, identifiable services and may be reported in conjunction with one another when appropriate. For angiography of noncoronary and nonpulmonary arteries and veins, performed as a distinct service, use appropriate codes from the Radiology section and the Vascular Injection Procedures section.

Angiography of the...

(Selective pulmonary angiography codes for cardiac catheterization [93569, 93573, 93574, 93575], include selective catheter positioning of the angiographic catheter, injection, and radiologic supervision and interpretation)

●*93593* *Right heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone; normal native connections*

●*93594* *abnormal native connections*

●*93595* *Left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone, normal or abnormal native connections*

●*93596*	*Right and left heart catheterization for congenital heart defect(s) including imaging guidance by the proceduralist to advance the catheter to the target zone(s); normal native connections*
●*93597*	*abnormal native connections*
+●*93598*	*Cardiac output measurement(s), thermodilution or other indicator dilution method, performed during cardiac catheterization for the evaluation of congenital heart defects (List separately in addition to code for primary procedure)*
	(Use 93598 in conjunction with 93593, 93594, 93595, 93596, 93597)
	(Do not report 93598 in conjunction with 93451-93461)
	(For pharmacologic agent administration during cardiac catheterization for congenital heart defect[s], use 93463)
	(For physiological exercise study with cardiac catheterization for congenital heart defect[s], use 93464)
	(For indicator dilution studies such as thermodilution for cardiac output measurement during cardiac catheterization for congenital heart defect[s], use 93598)
	(For contrast injections during cardiac catheterization for congenital heart defect[s], see 93563, 93564, 93565, 93566, 93567, 93568, 93569, 93573, 93574, 93575)
	(For angiography or venography not described in the 90000 series code section, see appropriate codes from the Radiology and the Medicine/Vascular Injection Procedure subsection)
	(For transseptal or transapical access of the left atrium during cardiac catheterization for congenital heart defect[s], use 93462 in conjunction with 93595, 93596, 93597, as appropriate)

Modifiers

CPT Level I Modifiers

63 Procedure Performed on Infants less than 4 kg

Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20100-69990 code series and 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93593, 93594, 93595, 93596, 93597, 9359893530, 93531, 93532, 93533, 93561, 93562, 93563, 93564, 93568, 93569, 93573, 93574, 93575, 93580, 93581, 93582, 93590, 93591, 93592, 93615, 93616 from the Medicine/Cardiovascular section. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections (other than those identified above from the Medicine/Cardiovascular section).

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93569 Tracking Number P7 Original Specialty Recommended RVU: **1.05**
Presented Recommended RVU: **1.05**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **1.05**

CPT Descriptor: Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, unilateral (list separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a diagnostic right heart cardiac catheterization, a 2-year-old female with prior history of repaired tetralogy of Fallot has selective branch pulmonary artery angiograms performed to evaluate for branch stenosis. Note: This is an add-on service. Only consider the additional work related to the nonselective pulmonary artery angiogram.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Diagnostic cardiac catheterization for both congenital as well as non-congenital indications includes the work of passing a diagnostic catheter into the main pulmonary artery. The work of 93569 begins when a wire is introduced through the diagnostic catheter to a more distal segmental pulmonary artery branch for selective catheterization. The diagnostic catheter is then either advanced over the wire and the wire removed for a selective hand injection or the diagnostic catheter is exchanged over the wire for an angiographic catheter to perform an angiogram with a power injector. Fluoroscopic guidance is used to confirm proper catheter position before angiography. Based on the findings from the initial imaging, additional angles may need to be acquired for better definition of suspected defects, and an angiographic injection is repeated. The patient's arterial pressure, electrocardiogram, and oxygen saturation are continuously monitored throughout the procedure. All images are reviewed and described in the procedure report. Per routine, any contrast injection is monitored afterward for complications of allergic reaction, arrhythmia, hemodynamic instability, and contrast-induced nephropathy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Mark Hoyer, MD; Ed Tuohy, MD					
Specialty Society(ies):	ACC & SCAI					
CPT Code:	93569					
Sample Size:	1373	**Resp N:**	32			
Description of Sample:	random samples of adult and pediatric interventional cardiologists					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	10.00	24.00	**40.00**	50.00	500.00	
Survey RVW:	0.43	1.05	**1.85**	2.33	9.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	4.00	8.00	**11.00**	21.00	50.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93569	**Recommended Physician Work RVU: 1.05**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**11.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93561	ZZZ	0.95	**RUC Time**

CPT Descriptor Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64484	ZZZ	1.00	**RUC Time**	431,178

CPT Descriptor 1 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64480	ZZZ	1.20	**RUC Time**	19,219

CPT Descriptor 2 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 28.1 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 15.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 93569	Top Key Reference CPT Code: 36227	2nd Key Reference CPT Code: **93561**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	11.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**11.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	33%	34%	22%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	22%	22%	56%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	22%	22%	56%
Physical effort required	22%	22%	56%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	45%	44%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	20%	60%	20%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	20%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	20%	80%
Physical effort required	0%	40%	60%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	40%	60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Panel approved a proposal at the May meeting to create four new codes that accurately describe pulmonary angiography procedures as they are currently performed. The CPT application sought to create the four new codes that would be used to report a significant portion—though not all—of the services now billed using 93568 and to make an editorial revision to 93568. With 93568 and a handful of adjacent angiography codes not reviewed in over a decade, the

societies undertook review of angiography codes 93563-93568 in addition to new codes 93569-93575. The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ-global day survey was completed by physicians who have experience with the services.

Compelling Evidence

As submitted, because the newly defined codes will be billed in lieu of one of the existing codes, the recommendations produce additional work RVUs, requiring compelling evidence. We offer three arguments for compelling evidence below that we believe explain differences between prior survey, differences in technique, and differences in patient population that support an estimated total of 613 RVUs for this family.

Pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. Existing CPT code 93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)* was created to describe pulmonary angiography with congenital as well as non-congenital cardiac catheterization. Among its inadequacies, it fails to describe any difference between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code fails to capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient. Availability of only a single CPT code which was supposed to capture these multiple injections was not sufficient and resulted in services being underdefined in CPT.

Incorrect Assumptions The prior survey included only traditional interventional cardiologists. No pediatric/congenital interventional cardiologists were explicitly included in the prior survey. Given the RUC methodology of a decade ago, when there were no pediatric or congenital interventional cardiologists surveyed, the societies believe including the correct comprehensive subsets of specialties and societies in the current survey demonstrates compelling evidence. These services are predominantly performed by physicians who were not included in the prior survey.

Change in Technique Complex angiographic techniques have been performed for decades to delineate the pulmonary anatomy. Yet only a single non-selective pulmonary arterial angiography code was ever available to capture this cumbersome and often, complex work. Code 93568, when created alone of the 4 standard angiograms that were performed in every case in the older days of cardiac catheterization: right ventricle, left ventricle, pulmonary artery, and aorta. Therefore, they created those 4 codes. Since that time, coders took it upon themselves to report this code for other instances, such as pulmonary veins. The term being pulmonary angiogram, seemed vague and they were able too successfully report it. In realty, the code was created for the MPA as a non-selective angiogram. Due to availability of small stents / balloons that can be enlarged to adequate size and can pass through small enough catheters, we now perform angioplasty / stenting on patients that 20 years ago, was not possible. However, angiograms in those patients was never addressed. The new codes are specific codes crafted to address other structures that never existed. Pulmonary veins and MAPCAs were never in the consideration when 93568 was created. For example, the submitted article by Soquet, et al, describes the change in management of pulmonary artresia with ventricular septal defect, that require information gleaned by pulmonary angiography. Adamson, et al, describe the complexity of managing patients with tetralogy of Fallot and major aortopulmonary collateral arteries (MAPCAs). Cory, et al, describe the evolution of techniques used to treat pediatric pulmonary vein stenosis.

Change in Patient Population As we have explained several other times in the congenital cardiac space in recent years, the patients who received these services 10 and 15 years ago were less complex than those we see today, the opposite of technology diffusion in many other areas of medicine where new technology is launched initially for the sickest.

Finally, as the specialty has evolved, several elements of the intra-service simply do not suit the work performed. Code 93568 for pulmonary angiography for cardiac catheterization does not include any catheter placement. That work is covered by the base diagnostic cardiac catheterization codes. For the non-congenital diagnostic catheter codes, further selective catheter placement was never included. For congenital cardiac catheterization, the older set of codes did include catheter positioning, however these codes have since been marked for deletion and are replaced by a new set of codes from May 2020 CPT meeting. In the newer congenital cardiac catheter codes, only non-selective catheter positioning is included for purposes of angiography and clearly stated as such in the DOW. A new code is then needed for selective

catheter placement, injection and RS&I which would be applicable to both congenital as well as non-congenital diagnostic cardiac catheter procedures.

Survey Analysis

As we move through recommendations for this large group of codes, it is important to keep several elements in mind.

- The six existing codes do not include introduction of catheters; that work is billed separately as part of the catheterization code, so the existing codes should have lower values than the newly created codes.
- **The new codes do include catheter placement as well as the injection and radiologic supervision and interpretation, reflecting more work as recommended in this submission.**
- With maturation of technology and a larger congenital population to benefit from interventions, these services are now very commonly provided in the congenital population.
- Prior survey of the existing codes over a decade ago did not include a pool of pediatric interventional cardiologists who are typically treating a different patient population than what was captured in that survey. We believe that difference calls into question the ability to compare the times of the current survey with those of the prior survey.
- **The expert panel finds the values for the new codes appropriate from a magnitude estimation perspective at the 25th-percentile work RVUs.**
- It is not clear to the expert panel from the survey results that survey respondents understood the distinction that the existing codes **do not** include selective catheter placement while new codes **do** incorporate selective catheter placement as part of the service. Therefore, we are recommending the current values for the existing codes, despite the fact they are below the 25th-percentile of the survey. We identify no rationale to argue compelling evidence for higher work RVUs for the existing codes based on the survey results, nor are we aware of changes to these services from the past decade since prior evaluation.
- We believe these recommendations maintain/create a reasonable rank order with most of the existing codes falling below the new codes that more specifically define angiography in the arteries and pulmonary veins.

Survey Results

The key reference code is 36227 for selective catheter placement in the external carotid artery. It was selected by 28% of respondents. 56% of the respondents indicated that 93569 was more complex. The second reference code is 93561 for indicator dilution studies during catheterization. It was selected by 16% of respondents. 80% of the respondents indicated that 93569 was more intense/complex overall.

93569 Recommendation

The societies recommend the survey 25th-percentile work RVW of 1.05 with 11 minutes intraservice time from the survey median. This value correctly falls below KRS, which has a longer intraservice time than 933X0. It also fits between MPC codes 64484 and 64480 that have times and RVUs just above and below the recommendation, as shown in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.

☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93568

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatric Interventional Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization not available

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 334
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 9356

Specialty cardiology Frequency 190 Percentage 56.88 %

Specialty interventional cardiology Frequency 90 Percentage 26.94 %

Specialty Pediatric Interventional Cardiology Frequency 34 Percentage 10.17 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93568

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93573 Tracking Number P8 Original Specialty Recommended RVU: **1.75**
Presented Recommended RVU: **1.75**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **1.75**

CPT Descriptor: Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, bilateral (list separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a diagnostic right heart cardiac catheterization, a 2-year-old girl with prior history of repaired tetralogy of Fallot has selective branch pulmonary artery angiograms performed to evaluate for branch stenosis. Note: This is an add-on service. Only consider the additional work related to the nonselective pulmonary artery angiogram.

Percentage of Survey Respondents who found Vignette to be Typical: 97%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Diagnostic cardiac catheterization for both congenital as well as non-congenital indications includes the work of passing a diagnostic catheter into the main pulmonary artery. The work of 93573 begins when a wire is introduced through the diagnostic catheter to further select a more distal segmental pulmonary artery branch for selective catheterization. The diagnostic catheter is then either advanced over the wire and the wire removed for a selective hand injection or the diagnostic catheter is exchanged over the wire for an angiographic catheter to perform an angiogram with a power injector. Fluoroscopic guidance is used to confirm proper catheter position before angiography. Based on the findings from the initial imaging, additional angles may need to be acquired for better definition of suspected defects, and an angiographic injection is repeated. Using the same or a differently shaped catheter, a wire is reinserted and used to enter the contralateral branch pulmonary artery and selectively position the catheter into another segmental pulmonary artery branch. The process above is repeated for contrast injection of the contralateral branch pulmonary artery. The patient's arterial pressure, electrocardiogram, and oxygen saturation are continuously monitored throughout the procedure. All images are reviewed and described in the procedure report. Per routine, any contrast injection is monitored afterward for complications of allergic reaction, arrhythmia, hemodynamic instability, and contrast-induced nephropathy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Mark Hoyer, MD; Ed Tuohy, MD					
Specialty Society(ies):	ACC & SCAI					
CPT Code:	93573					
Sample Size:	1373	**Resp N:**	33			
Description of Sample:	Adult and pediatric interventional cardiologists					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	5.00	25.00	**30.00**	50.00	300.00
Survey RVW:	0.65	1.75	**2.12**	2.50	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	12.00	**18.00**	30.00	110.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93573	**Recommended Physician Work RVU: 1.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**18.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93561	ZZZ	2.09	**RUC Time**

CPT Descriptor Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	91,408

CPT Descriptor 1 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99292	ZZZ	2.25	**RUC Time**	560,661

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

Other Reference CPT Code	Global	Work RVU	Time Source
36483	ZZZ	1.75	**RUC Time**

CPT Descriptor Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 9 **% of respondents:** 27.2 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 15.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 93573	Top Key Reference CPT Code: 36227	2nd Key Reference CPT Code: **93561**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	18.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**18.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	11%	11%	56%	22%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	11%	22%	67%

• Urgency of medical decision making	

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	22%	67%
Physical effort required	11%	44%	44%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	33%	56%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	0%	20%	80%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	20%	80%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	100%
Physical effort required	0%	0%	100%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	20%	80%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Panel approved a proposal at the May meeting to create four new codes that accurately describe pulmonary angiography procedures as they are currently performed. Pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. Existing CPT code 93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)* was created in the late 1990s to describe pulmonary angiography with congenital as well as non-congenital cardiac catheterization. Among its inadequacies, it fails to describe any difference between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code fails to capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient. Availability of only a single CPT code intended to capture these multiple injections was not sufficient and resulted in services being underdefined in CPT.

The CPT application sought to create the four new codes that would be used to report a significant portion—though not all—of the services now billed using 93568 and to make an editorial revision to 93568. With 93568 and a handful of adjacent angiography codes not reviewed in over a decade, the societies undertook review of angiography codes 93563-93568 in addition to new codes 93569-93575. The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ-global day survey was completed by physicians who have experience with the services.

As we move through recommendations for this large group of codes, it is important to keep several elements in mind.

- The six existing codes **do not** include introduction of catheters; that work is billed separately as part of the catheterization code, so the existing codes should have lower values than the newly created codes.
- The new codes **do** include catheter placement as well as the injection and radiologic supervision and interpretation, reflecting more work as recommended in this submission.
- With maturation of technology and a larger congenital population to benefit from interventions, these services are now very commonly provided in the congenital population.
- Prior survey of the existing codes over a decade ago did not include a pool of pediatric interventional cardiologists who are typically treating a different patient population than what was captured in that survey. We believe that difference calls into question the ability to compare the times of the current survey with those of the prior survey.
- The expert panel finds the values for the new codes appropriate from a magnitude estimation perspective at the 25th-percentile work RVUs.
- It is not clear to the expert panel from the survey results that survey respondents understood the distinction that the existing codes **do not** include selective catheter placement while new codes **do** incorporate selective catheter placement as part of the service. Therefore, we are recommending the current values for the existing codes, despite the fact they are below the 25th-percentile of the survey. We identify no rationale to argue compelling evidence for higher work RVUs for the existing codes based on the survey results, nor are we aware of changes to these services from the past decade since prior evaluation.
- We believe these recommendations maintain/create a reasonable rank order with most of the existing codes falling below the new codes that more specifically define angiography in the arteries and pulmonary veins.

Survey Results

The key reference code is 36227 for selective catheter placement in the external carotid artery. It was selected by 27% of respondents. 78% of the respondents indicated that 93573 was more complex. The second reference code is 93561 for indicator dilution studies during catheterization. It was selected by 15% of respondents. 100% of the respondents indicated that 93573 was more intense/complex overall.

93573 Recommendation

The societies recommend the survey 25th-percentile work RVW of 1.75 with 18 minutes intraservice time from the survey median. It also fits between MPC codes 37253 and 99292 that have times and RVUs just above and below the recommendation, as shown in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93568

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatric Interventional Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization not available

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 334
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The CPT CCA estimates 25% of 93568 will be reported as 93573.

Specialty Cardiology Frequency 190 Percentage 56.88 %

Specialty Interventional Cardiology Frequency 90 Percentage 26.94 %

Specialty Pediatric Interventional Cardiology Frequency 34 Percentage 10.17 %

Do many physicians perform this service across the United States? No

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93568

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93574 Tracking Number P9 Original Specialty Recommended RVU: **1.84**
Presented Recommended RVU: **1.84**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **1.84**

CPT Descriptor: Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization. (list separately in addition to code for primary procedure) (use 93xx2 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, 37236, 37237, 37238, 37246, 37248, 338x1, 338x2, 338x3, 338x4, 338x5, 338x6, 338x7, 37187, 37188, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, 93x1x, 93x2x, 93x3x, 93x4x, 93x5x, 93505, 93580, 93581, 93582, 93583)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a diagnostic cardiac catheterization, a 6-month-old male with down syndrome, status post atrioventricular (av) canal repair with new pulmonary hypertension undergoes multiple selective pulmonary venous angiograms to evaluate for presence of any pulmonary vein stenosis. note: this is an add-on service. only consider the additional work related to each additional distinct pulmonary vein angiogram

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Diagnostic cardiac catheterization for both congenital as well as non-congenital indications includes the work of passing a diagnostic catheter into the pulmonary venous atrium. The work of 93574 begins after diagnostic catheterization and after achieving catheter position in the pulmonary venous atrium. An endhole catheter and wire are used to selectively enter a single pulmonary vein ostium. Once a pulmonary vein is securely engaged with the catheter, the wire is removed, observing appropriate de-airing of the catheter. A hand injection angiogram is performed within the vein and reviewed in real time for any abnormalities. After pressure pullback from the pulmonary vein to the atrium, the catheter is disconnected from the transducer, and the guidewire is re-inserted to repeat the process by probing for a different pulmonary vein ostium. Once a 2nd vein is selectively engaged, angiography is repeated to evaluate this vein for any abnormalities. This process may be repeated as many as 4-5 times, selectively entering each distinct pulmonary vein that directly enters the pulmonary venous atrium, and each distinct vessel is additionally reportable. The patient's arterial pressure, electrocardiogram, and oxygen saturation are continuously monitored throughout the procedure. All images are reviewed and described in the procedure report. Per routine, any contrast injection is monitored afterward for complications of allergic reaction, arrhythmia, hemodynamic instability, and contrast-induced nephropathy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Mark Hoyer, MD; Edward Toggart, MD; Edu Tuohy, MD					
Specialty Society(ies):	ACC & SCAI					
CPT Code:	93574					
Sample Size:	1373	**Resp N:**	32			
Description of Sample:	Adult and pediatric interventional cardiologists					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	4.00	10.00	**20.00**	40.00	200.00	
Survey RVW:	0.58	1.84	**2.43**	3.00	10.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	5.00	10.00	**20.00**	26.00	80.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93574	**Recommended Physician Work RVU: 1.84**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92978	ZZZ	1.80	**RUC Time**

CPT Descriptor Endoluminal imaging of coronary vessel or graft using intravascular ultrasound (IVUS) or optical coherence tomography (OCT) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	91,408

CPT Descriptor 1 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99292	ZZZ	2.25	**RUC Time**	560,661

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)

Other Reference CPT Code	Global	Work RVU	Time Source
36483	ZZZ	1.75	**RUC Time**

CPT Descriptor Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous;

subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 12 **% of respondents:** 37.5 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 15.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 93574	Top Key Reference CPT Code: 36227	2nd Key Reference CPT Code: **92978**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	20.00	15.00	25.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**15.00**	**25.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	8%	8%	25%	59%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	17%	66%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	8%	84%
Physical effort required	17%	8%	75%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	42%	50%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	20%	60%	20%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	20%	80%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	100%
Physical effort required	0%	40%	60%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	60%	40%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Panel approved a proposal at the May meeting to create four new codes that accurately describe pulmonary angiography procedures as they are currently performed. Pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. Existing CPT code 93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)* was created in the late 1990s to describe pulmonary angiography with congenital as well as non-congenital cardiac catheterization. Among its inadequacies, it fails to describe any difference between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code fails to capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient. Availability of only a single CPT code intended to capture these multiple injections was not sufficient and resulted in services being underdefined in CPT.

The CPT application sought to create the four new codes that would be used to report a significant portion—though not all—of the services now billed using 93568 and to make an editorial revision to 93568. With 93568 and a handful of adjacent angiography codes not reviewed in over a decade, the societies undertook review of angiography codes 93563-93568 in addition to new codes 93569-93575. The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ-global day survey was completed by physicians who have experience with the services.

As we move through recommendations for this large group of codes, it is important to keep several elements in mind.

- The six existing codes **do not** include introduction of catheters; that work is billed separately as part of the catheterization code, so the existing codes should have lower values than the newly created codes.
- The new codes **do** include catheter placement as well as the injection and radiologic supervision and interpretation, reflecting more work as recommended in this submission.
- With maturation of technology and a larger congenital population to benefit from interventions, these services are now very commonly provided in the congenital population.
- Prior survey of the existing codes over a decade ago did not include a pool of pediatric interventional cardiologists who are typically treating a different patient population than what was captured in that survey. We believe that difference calls into question the ability to compare the times of the current survey with those of the prior survey.
- The expert panel finds the values for the new codes appropriate from a magnitude estimation perspective at the 25th-percentile work RVUs.
- It is not clear to the expert panel from the survey results that survey respondents understood the distinction that the existing codes **do not** include selective catheter placement while new codes **do** incorporate selective catheter placement as part of the service. Therefore, we are recommending the current values for the existing codes, despite the fact they are below the 25th-percentile of the survey. We identify no rationale to argue compelling evidence for higher work RVUs for the existing codes based on the survey results, nor are we aware of changes to these services from the past decade since prior evaluation.
- We believe these recommendations maintain/create a reasonable rank order with most of the existing codes falling below the new codes that more specifically define angiography in the arteries and pulmonary veins.

Survey Results

The key reference code is 36227 for selective catheter placement in the external carotid artery. It was selected by 37% of respondents. 84% of the respondents indicated that 93574 was more complex. The second reference code is 92978 for IVUS or OCT. It was selected by 15% of respondents. 80% of the respondents indicated that 93574 was more intense/complex overall.

93574 Recommendation

The societies recommend the survey 25th-percentile work RVW of 1.84 with 20 minutes intraservice time from the survey median. It also fits between MPC codes 37253 and 99292 that have times and RVUs just above and below the recommendation, as shown in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93568

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatric Interventional Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization is not available.

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 133
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The CPT CCA estimates 10% of 93568 will be reported as 93574.

Specialty Cardiology Frequency 75 Percentage 56.39 %

Specialty Interventional Cardiology Frequency 35 Percentage 26.31 %

Specialty Pediatric Interventional Cardiology Frequency 14 Percentage 10.52 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93568

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93575 Tracking Number P10 Original Specialty Recommended RVU: **1.92**
Presented Recommended RVU: **1.92**
Global Period: ZZZ Current Work RVU: RUC Recommended RVU: **1.92**

CPT Descriptor: Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary angiography of major aortopulmonary collateral arteries (mapcas) arising off the aorta or its systemic branches, each distinct vessel (use 93575 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, 37236, 37237, 37238, 37246, 37248, 338x1, 338x2, 338x3, 338x4, 338x5, 338x6, 338x7, 37187, 37188, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, 93x1x, 93x2x, 93x3x, 93x4x, 93x5x, 93505, 93580, 93581, 93582, 93583)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a diagnostic cardiac catheterization, a 1-week-old female with pulmonary valve atresia, ventricular septal defect (vsd), and major aortopulmonary collateral arteries (mapcas), undergoes several selective angiograms of mapca vessels supplying pulmonary blood flow from the aorta. note: this is an add-on service. only consider the additional work related to each selective pulmonary artery angiogram from an arterial (left heart) approach.

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Diagnostic cardiac catheterization for both congenital as well as non-congenital indications includes the work of passing a diagnostic catheter into the aorta. The work of 93573 begins after diagnostic catheterization. An endhole catheter is passed with the aid of a guidewire from the arterial system and used to probe for and selectively catheterize individual pulmonary arteries, arterial collaterals, or surgical shunts supplying pulmonary blood flow from the aorta. Once the catheter is securely within one of the target vessels, the wire is removed and the catheter is de-aired. A hand injection angiogram is performed within the vessel and reviewed in real time for any abnormalities. A pressure is recorded, as needed. The catheter is withdrawn into the aorta and the guidewire is re-inserted to repeat the process by probing for a different target vessel. Once a second target vessel is selectively engaged, angiography is repeated to evaluate this vessel for any abnormalities. This entire process is repeated as many times as needed until all suspected vessels supplying flow from the aorta to the pulmonary circulation are identified, and each distinct named vessel is additionally reportable. The patient's arterial pressure, electrocardiogram, and oxygen saturation are continuously monitored throughout the procedure. All images are reviewed and described in the procedure report. Per routine, any contrast injection is monitored afterward for complications of allergic reaction, arrhythmia, hemodynamic instability, and contrast-induced nephropathy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Thard Waites, MD; Edward Toggart,MD; Mark Hoyer, MD; Ed Tuohy, MD					
Specialty Society(ies):	ACC& SCAI					
CPT Code:	93575					
Sample Size:	1373	**Resp N:**	33			
Description of Sample:	Adult and pediatric interventional cardiologists					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	5.00	**9.00**	15.00	100.00
Survey RVW:	0.46	1.92	**2.35**	3.10	10.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	5.00	10.00	**20.00**	31.00	120.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93575	**Recommended Physician Work RVU: 1.92**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92973	ZZZ	3.28	**RUC Time**

CPT Descriptor Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
37253	ZZZ	1.44	**RUC Time**	91,408

CPT Descriptor 1 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99292	ZZZ	2.25	**RUC Time**	560,661

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service

Other Reference CPT Code	Global	Work RVU	Time Source
36483		0.00	

CPT Descriptor Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 **% of respondents:** 45.4 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 12.1 **%**

TIME ESTIMATES (Median)

	CPT Code: 93575	Top Key Reference CPT Code: 36227	2nd Key Reference CPT Code: **92973**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	20.00	15.00	40.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**20.00**	**15.00**	**40.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	7%	26%	60%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	7%	20%	73%

- Urgency of medical decision making

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	0%	93%
Physical effort required	7%	13%	80%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	33%	67%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	50%	25%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	75%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	100%
Physical effort required	0%	50%	51%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	25%	75%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Panel approved a proposal at the May meeting to create four new codes that accurately describe pulmonary angiography procedures as they are currently performed. Pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. Existing CPT code 93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)* was created in the late 1990s to describe pulmonary angiography with congenital as well as non-congenital cardiac catheterization. Among its inadequacies, it fails to describe any difference between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code fails to capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient. Availability of only a single CPT code intended to capture these multiple injections was not sufficient and resulted in services being underdefined in CPT.

The CPT application sought to create the four new codes that would be used to report a significant portion—though not all—of the services now billed using 93568 and to make an editorial revision to 93568. With 93568 and a handful of adjacent angiography codes not reviewed in over a decade, the societies undertook review of angiography codes 93563-93568 in addition to new codes 93569-93575. The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ-global day survey was completed by physicians who have experience with the services.

As we move through recommendations for this large group of codes, it is important to keep several elements in mind.

- The six existing codes **do not** include introduction of catheters; that work is billed separately as part of the catheterization code, so the existing codes should have lower values than the newly created codes.
- The new codes **do** include catheter placement as well as the injection and radiologic supervision and interpretation, reflecting more work as recommended in this submission.
- With maturation of technology and a larger congenital population to benefit from interventions, these services are now very commonly provided in the congenital population.
- Prior survey of the existing codes over a decade ago did not include a pool of pediatric interventional cardiologists who are typically treating a different patient population than what was captured in that survey. We believe that difference calls into question the ability to compare the times of the current survey with those of the prior survey.
- The expert panel finds the values for the new codes appropriate from a magnitude estimation perspective at the 25th-percentile work RVUs.
- It is not clear to the expert panel from the survey results that survey respondents understood the distinction that the existing codes **do not** include selective catheter placement while new codes **do** incorporate selective catheter placement as part of the service. Therefore, we are recommending the current values for the existing codes, despite the fact they are below the 25th-percentile of the survey. We identify no rationale to argue compelling evidence for higher work RVUs for the existing codes based on the survey results, nor are we aware of changes to these services from the past decade since prior evaluation.
- We believe these recommendations maintain/create a reasonable rank order with most of the existing codes falling below the new codes that more specifically define angiography in the arteries and pulmonary veins.

Survey Results

The key reference code is 36227 for selective catheter placement in the external carotid artery. It was selected by 45% of respondents. 86% of the respondents indicated that 93575 was more complex. The second reference code is 92973 for percutaneous transluminal coronary thrombectomy. It was selected by 12% of respondents. 50% of the respondents indicated that 93575 was more intense/complex overall.

93575 Recommendation

The societies recommend the survey 25th-percentile work RVW of 1.92 with 20 minutes intraservice time from the survey median. It also fits between MPC codes 37253 and 99292 that have times and RVUs just above and below the recommendation, as shown in the summary spreadsheet.

In comparison to code prior code 93575 that also has 20 minutes intraservice time, this code is for each distinct pulmonary vein and requires more work, often using different catheter shapes and wires to enter separate pulmonary veins. If 3-5 pulmonary veins branches are separately and selectively entered, there is considerably more work even from a time perspective to complete these tasks. 93754 is for bilateral selective pulmonary artery angiography, which is relatively more straightforward, though challenges can occur with hypoplastic branch pulmonary arteries. Pulmonary veins are generally more predictable in number (~3-5) and drain more predictably to the left atrium, though they may be stenotic or have anomalous drainage, requiring more effort. MAPCA's, on the other hand, have some more common origins from the descending thoracic aorta but can literally come from just about anywhere. They arise from the aorta, but with variable angles, from the arch, from arch vessels, and also abdominal aorta. There may be 1 or 10 or more, depending on the individual. These are quite challenging yet essential to understand for optimal patient management.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93568

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatric Interventional Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization data not available.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 133
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The CPT CCA estimates 10% of 93568 will be reported as 93575.

Specialty Cardiology Frequency 75 Percentage 56.39 %

Specialty Interventional Cardiology Frequency 35 Percentage 26.31 %

Specialty Pediatric Interventional Cardiology Frequency 14 Percentage 10.52 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 93568

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93563 Tracking Number P1 Original Specialty Recommended RVU: **1.11**
Presented Recommended RVU: **1.11**
Global Period: ZZZ Current Work RVU: **1.11** RUC Recommended RVU: **1.11**

CPT Descriptor: Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (list separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with progressive chest pain is undergoing diagnostic heart catheterization (reported using congenital catheterization codes 93530-93533) including coronary angiography. [Note: When completing this survey, only consider the "additional" physician work related to 93563.]

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Diagnostic congenital catheterization codes include the work of passing a catheter into the aortic rootcoronary artery(ies). The work of 93563 begins when after the catheter is manipulated positioned into the ostium of a coronary artery using fluoroscopic guidance into the ostium of a coronary artery. The arterial pressure and waveform are checked to be sure there is no evidence of catheter malposition or impairment of coronary flow due to an ostial stenosis. Test contrast injections under fluoroscopy are performed using fluoroscopy to check confirm catheter position. Multiple coronary injections are performed, with different radiographic angles, as needed, to optimally define coronary anatomy. Panning of the table is usually performed to ensure visualization of the vessels throughout their lengths.each with the imaging system aligned in a different orientation, with simultaneous panning (moving the table) to assess for stenoses. The catheter is then removed over the wire. Additional catheters are introduced over the guide wire and manipulated into the ostium (a) ofused to inject other coronary artery(iess)) in) to inject them in multiple views, as needed. while moving the table in similar fashion. Injections are performed using a power injector device or by hand. Typically, a separate catheter is used for the left and right coronary arteries. The patient's arterial pressure, electrocardiogram, and oxygen saturation are continuouslystantly monitored throughout the procedure. Additional All images obtained by coronary angiography are reviewed and are described in the report of the procedure report. Per routine, any contrast injection is monitored afterward for complications of allergic reaction, arrhythmia, hemodynamic instability, and contrast-induced nephropathy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Mark Hoyer, MD; Ed Touhy, MD					
Specialty Society(ies):	ACC & SCAI					
CPT Code:	93563					
Sample Size:	1373	**Resp N:**	35			
Description of Sample:	adult and pediatric interventionalists					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	1.00	12.00	**25.00**	50.00	125.00	
Survey RVW:	0.70	1.32	**2.00**	2.20	6.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	4.00	10.00	**15.00**	24.00	90.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93563	**Recommended Physician Work RVU: 1.11**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93571	ZZZ	1.38	**RUC Time**

CPT Descriptor Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64480	ZZZ	1.20	**RUC Time**	19,219

CPT Descriptor 1 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52442	ZZZ	1.01	**RUC Time**	101,717

CPT Descriptor 2 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 16 **% of respondents:** 45.7 **%**

Number of respondents who choose 2nd Key Reference Code: 5 **% of respondents:** 14.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 93563	Top Key Reference CPT Code: 36227	2nd Key Reference CPT Code: **93571**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	15.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**15.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	31%	69%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	31%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	6%	19%	75%
Physical effort required	6%	50%	44%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	38%	62%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	40%	0%	0%	60%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	20%	60%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	40%	0%	600%
Physical effort required	0%	40%	60%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	40%	0%	60%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Panel approved a proposal at the May meeting to create four new codes that accurately describe pulmonary angiography procedures as they are currently performed. Pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture

the variability encountered. Existing CPT code 93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)* was created in the late 1990s to describe pulmonary angiography with congenital as well as non-congenital cardiac catheterization. Among its inadequacies, it fails to describe any difference between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code fails to capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient. Availability of only a single CPT code intended to capture these multiple injections was not sufficient and resulted in services being underdefined in CPT.

The CPT application sought to create the four new codes that would be used to report a significant portion—though not all—of the services now billed using 93568 and to make an editorial revision to 93568. With 93568 and a handful of adjacent angiography codes not reviewed in over a decade, the societies undertook review of angiography codes 93563-93568 in addition to new codes 93569-93575. The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ-global day survey was completed by physicians who have experience with the services.

As we move through recommendations for this large group of codes, it is important to keep several elements in mind.

- The six existing codes **do not** include introduction of catheters; that work is billed separately as part of the catheterization code, so the existing codes should have lower values than the newly created codes.
- The new codes **do** include catheter placement as well as the injection and radiologic supervision and interpretation, reflecting more work as recommended in this submission.
- With maturation of technology and a larger congenital population to benefit from interventions, these services are now very commonly provided in the congenital population.
- Prior survey of the existing codes over a decade ago did not include a pool of pediatric interventional cardiologists who are typically treating a different patient population than what was captured in that survey. We believe that difference calls into question the ability to compare the times of the current survey with those of the prior survey.
- The expert panel finds the values for the new codes appropriate from a magnitude estimation perspective at the 25th-percentile work RVUs.
- It is not clear to the expert panel from the survey results that survey respondents understood the distinction that the existing codes **do not** include selective catheter placement while new codes **do** incorporate selective catheter placement as part of the service. Therefore, we are recommending the current values for the existing codes, despite the fact they are below the 25th-percentile of the survey. We identify no rationale to argue compelling evidence for higher work RVUs for the existing codes based on the survey results, nor are we aware of changes to these services from the past decade since prior evaluation.
- We believe these recommendations maintain/create a reasonable rank order with most of the existing codes falling below the new codes that more specifically define angiography in the arteries and pulmonary veins.

Incorrect Code Descriptor

During review of materials for submission, it was discovered that through a clerical error following the May 2020 CPT Editorial Panel meeting, the code descriptors for 93563 and 93564 errantly included language in the CPT Coding Changes document that stated added "including catheter placement(s) when performed." The language has been corrected in submitted materials here but is still apparent in the CPT Coding Changes document and is shown below for clarity.

93563 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization, including catheter placement(s) when performed (list separately in addition to code for primary procedure)

93564 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, including catheter placement(s) when performed (list separately in addition to code for primary procedure)

This language was included in the survey tool and not discovered until soon before submission of materials. This error may partially explain why the survey RVU responses for 93563 and 93564 trended a bit higher than the other existing codes. However, 93563 and 93564 were historically a bit higher than 93565-93568, so it may also be the case that survey respondents responded based on their familiarity of the past decade, thinking that catheter placement is part of the underlying catheterization code. Reviewing the data, it is not clear to us that either is the case or that the error significantly impacted the survey, and in any event, our recommendations are to maintain the values.

Survey Results

The key reference code is 36227 for selective catheter placement in the external carotid artery. It was selected by 46% of respondents. 69% of the respondents indicated that 93563 was somewhat more complex. The second reference code is 93571 for intravascular Doppler velocity and/or pressure flow reserve measurement during angiography. It was selected by 14% of respondents, with a mix of responses indicating more or less intensity.

93563 Recommendation

The societies recommend the existing value of 1.11 work RVUs with 15 minutes intraservice time from the survey median. As noted above, this value falls below the survey 25th-percentile RVU. The expert panel believes this code and other current values for existing codes align with the recommended values at the 25th for the new codes. This value correctly fits between MPC codes 64480 and 52442 that have identical times of 15 minutes with RVUs just above and below the recommendation, as shown in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93563

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty pediatric interventional cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 167
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization

Specialty cardiology Frequency 70 Percentage 41.91 %

Specialty pediatric interventinal cardiology Frequency 60 Percentage 35.92 %

Specialty interventional cardiology Frequency 35 Percentage 20.95 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93563

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93564 Tracking Number P2 Original Specialty Recommended RVU: **1.13**
Presented Recommended RVU: **1.13**
Global Period: ZZZ Current Work RVU: **1.13** RUC Recommended RVU: **1.13**

CPT Descriptor: Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (list separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with history of congenital heart disease and coronary artery bypass surgery now has recurrence of typical angina necessitating diagnostic heart catheterization (reported using congenital catheterization codes 93530-93533) with additional contrast injection(s) for selective opacification of aortocoronary venous or arterial bypass graft(s), one or more coronary arteries and, if indicated, imaging for selective opacification of native/bypass arterial conduits is also performed.

Percentage of Survey Respondents who found Vignette to be Typical: 96%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Diagnostic congenital catheterization codes include the work of passing a catheter into the bypass grafts. Fluoroscopic guidance of catheter manipulation is used throughout the procedure. The work of 93564 begins after the catheter is positioned into the ostium of a bypass graft. The arterial pressure and waveform are checked to be sure there is no evidence of catheter malposition or impairment of graft flow due to an ostial stenosis. Test contrast injections are performed using fluoroscopy to confirm catheter position. Multiple graft or in situ arterial conduit injections are performed with different radiographic angles, as needed, to optimally define graft and coronary anatomy. Panning of the table is usually performed to ensure visualization of the vessels throughout their lengths. Additional catheters are used to inject other aorto-coronary artery grafts or in situ arterial conduits (e.g. internal mammary artery grafts) in multiple views, as needed. Injections are performed using a power injector device or by hand. The patient's arterial pressure, electrocardiogram, and oxygen saturation are continuously monitored throughout the procedure. All images are reviewed and described in the procedure report. Per routine, any contrast injection is monitored afterward for complications of allergic reaction, arrhythmia, hemodynamic instability, and contrast-induced nephropathy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Mark Hoyer, MD; Ed Tuohy, MD					
Specialty Society(ies):	ACC & SCAI					
CPT Code:	93564					
Sample Size:	1373	**Resp N:**	25			
Description of Sample:	Adult and pediatric interventional cardiologists					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**2.00**	4.00	50.00	
Survey RVW:	1.00	1.67	**2.20**	2.40	7.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	5.00	12.00	**18.00**	25.00	120.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93564	**Recommended Physician Work RVU: 1.13**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**18.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93571	ZZZ	1.38	**RUC Time**

CPT Descriptor Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64480	ZZZ	1.20	**RUC Time**	19,219

CPT Descriptor 1 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), cervical or thoracic, each additional level (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52442	ZZZ	1.01	**RUC Time**	101,717

CPT Descriptor 2 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 14 **% of respondents:** 56.0 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 16.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 93564	Top Key Reference CPT Code: 36227	2nd Key Reference CPT Code: **93571**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	18.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**18.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	21%	79%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	29%	71%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	14%	79%
Physical effort required	7%	43%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	43%	57%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	50%	0%	50%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	25%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	0%	100%
Physical effort required	0%	25%	75%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Panel approved a proposal at the May meeting to create four new codes that accurately describe pulmonary angiography procedures as they are currently performed. Pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture

the variability encountered. Existing CPT code 93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)* was created in the late 1990s to describe pulmonary angiography with congenital as well as non-congenital cardiac catheterization. Among its inadequacies, it fails to describe any difference between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code fails to capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient. Availability of only a single CPT code intended to capture these multiple injections was not sufficient and resulted in services being underdefined in CPT.

The CPT application sought to create the four new codes that would be used to report a significant portion—though not all—of the services now billed using 93568 and to make an editorial revision to 93568. With 93568 and a handful of adjacent angiography codes not reviewed in over a decade, the societies undertook review of angiography codes 93563-93568 in addition to new codes 93569-93575. The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ-global day survey was completed by physicians who have experience with the services.

As we move through recommendations for this large group of codes, it is important to keep several elements in mind.

- The six existing codes **do not** include introduction of catheters; that work is billed separately as part of the catheterization code, so the existing codes should have lower values than the newly created codes.
- The new codes **do** include catheter placement as well as the injection and radiologic supervision and interpretation, reflecting more work as recommended in this submission.
- With maturation of technology and a larger congenital population to benefit from interventions, these services are now very commonly provided in the congenital population.
- Prior survey of the existing codes over a decade ago did not include a pool of pediatric interventional cardiologists who are typically treating a different patient population than what was captured in that survey. We believe that difference calls into question the ability to compare the times of the current survey with those of the prior survey.
- The expert panel finds the values for the new codes appropriate from a magnitude estimation perspective at the 25th-percentile work RVUs.
- It is not clear to the expert panel from the survey results that survey respondents understood the distinction that the existing codes **do not** include selective catheter placement while new codes **do** incorporate selective catheter placement as part of the service. Therefore, we are recommending the current values for the existing codes, despite the fact they are below the 25th-percentile of the survey. We identify no rationale to argue compelling evidence for higher work RVUs for the existing codes based on the survey results, nor are we aware of changes to these services from the past decade since prior evaluation.
- We believe these recommendations maintain/create a reasonable rank order with most of the existing codes falling below the new codes that more specifically define angiography in the arteries and pulmonary veins.

Incorrect Code Descriptor

During review of materials for submission, it was discovered that through a clerical error following the May 2020 CPT Editorial Panel meeting, the code descriptors for 93563 and 93564 errantly included language in the CPT Coding Changes document that stated added "including catheter placement(s) when performed." The language has been corrected in submitted materials here but is still apparent in the CPT Coding Changes document and is shown below for clarity.

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93564 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, including catheter placement(s) when performed (list separately in addition to code for primary procedure)

This language was included in the survey tool and not discovered until soon before submission of materials. This error may partially explain why the survey RVU responses for 93563 and 93564 trended a bit higher than the other existing codes. However, 93563 and 93564 were historically a bit higher than 93565-93568, so it may also be the case that survey respondents responded based on their familiarity of the past decade, thinking that catheter placement is part of the underlying catheterization code. Reviewing the data, it is not clear to us that either is the case or that the error significantly impacted the survey, and in any event, our recommendations are to maintain the values.

Survey Results

The key reference code is 36227 for selective catheter placement in the external carotid artery. It was selected by 56% of respondents. 79% of the respondents indicated that 93564 was somewhat more complex. The second reference code is 93571 for intravascular Doppler velocity and/or pressure flow reserve measurement during angiography. It was selected by 16% of respondents, with half indicating identical intensity/complexity and half indication more intensity/complexity.

We do note here, and discussed at prefacilitation, that the survey threshold of 30 was not met for this service. In consultation with RUC staff, we re-opened we re-opened the survey and contacted those who skipped 93564 to see if they would go back to complete the survey. This effort produced only 1 additional response, so we have not amended our submission because it is still short. This service is extremely rare—6 units in 2019 MPFS—and the prefacilitation committee did not feel it would be disqualifying in this instance.

93564 Recommendation

The societies recommend the existing value of 1.13 work RVUs with 18 minutes intraservice time from the survey median. As noted above, this value falls below the survey 25th-percentile RVU. The expert panel believes this code and other current values for existing codes align with the recommended values at the 25th for the new codes. This value correctly fits between MPC codes 64480 and 52442 that have slightly shorter times of 15 minutes with RVUs just above and below the recommendation, as shown in the summary spreadsheet.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.

☐ Historical precedents.
☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93564

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty pediatric interventional cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate not available

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 6 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization data

Specialty pediatric interventional cardiology Frequency 4 Percentage 66.66 %

Specialty cardiology Frequency 2 Percentage 33.33 %

Specialty Frequency 0 Percentage %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93564

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93565 Tracking Number P3 Original Specialty Recommended RVU: **0.86**
Presented Recommended RVU: **0.86**
Global Period: ZZZ Current Work RVU: **0.86** RUC Recommended RVU: **0.86**

CPT Descriptor: Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with a prominent systolic murmur has progressive dyspnea on exertion necessitating diagnostic heart catheterization (reported using congenital catheterization codes 93530-93533) with additional contrast injection(s) for imaging for left ventriculogram/ atrial angiography. [Note: When completing this survey, only consider the "additional" physician work related to 93565.]

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Diagnostic congenital or non-congenital catheterization codes include the work of passing a catheter into the left ventricle. The work of 93565 begins when the catheter is then attached to a power injector with careful removal of air from the tubing. Fluoroscopic guidance is used to ensure proper catheter position. Power injection is then performed in appropriate angiographic views to fully opacify the ventricle, allowing evaluation of systolic function, competence of the mitral valve, ventriculo-arterial connection, and presence and location of any ventricular septal defects or outflow obstruction. The power injector is disconnected from the catheter, the catheter is reattached to the manifold, and any air is again removed. The patient's arterial pressure, electrocardiogram, and oxygen saturation are continuously monitored throughout the procedure. Images are reviewed and described in the procedure report. Per routine, any contrast injection is monitored afterward for complications of allergic reaction, arrhythmia, hemodynamic instability, and contrast-induced nephropathy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Mark Hoyer, MD; Ed Tuohy, MD					
Specialty Society(ies):	ACC & SCAI					
CPT Code:	93565					
Sample Size:	1373	**Resp N:**	34			
Description of Sample:	Adult and pediatric interventional congenitalists					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	6.00	20.00	**45.00**	83.00	200.00	
Survey RVW:	0.63	1.00	**1.25**	2.05	8.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	2.00	7.00	**10.00**	20.00	60.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93565	**Recommended Physician Work RVU: 0.86**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (list separately in addition to code for primary procedure) (use 93566 in conjunction with 93451, 93453, 93456, 93457, 93460, 93461, 93x1x, 93x2x, 93x3x, 93x4x, 93x5x, 93582) (do not report 93566 in conjunction with 33274 for right ventriculography performed during leadless pacemaker insertion) (do not report 93566 in conjunction with 0545t for right ventricular or right atrial angiography procedures intrinsic to the annulus reconstruction procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93561	ZZZ	0.95	**RUC Time**

CPT Descriptor Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64484	ZZZ	1.00	**RUC Time**	431,178

CPT Descriptor 1 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedur

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
51797	ZZZ	0.80	**RUC Time**	116,064

CPT Descriptor 2 Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
15274	ZZZ	0.80	**RUC Time**

CPT Descriptor Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 23.5 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 23.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 93565	Top Key Reference CPT Code: 36227	2nd Key Reference CPT Code: **93561**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	10.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**10.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	13%	50%	37%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	25%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	25%	63%	12%
Physical effort required	25%	63%	12%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	25%	38%	37%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	37%	38%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	38%	49%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	38%	62%
Physical effort required	0%	62%	38%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	38%	62%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Panel approved a proposal at the May meeting to create four new codes that accurately describe pulmonary angiography procedures as they are currently performed. Pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. Existing CPT code 93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)* was created in the late 1990s to describe pulmonary angiography with congenital as well as non-congenital cardiac catheterization. Among its inadequacies, it fails to describe any difference between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code fails to capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient. Availability of only a single CPT code intended to capture these multiple injections was not sufficient and resulted in services being underdefined in CPT.

The CPT application sought to create the four new codes that would be used to report a significant portion—though not all—of the services now billed using 93568 and to make an editorial revision to 93568. With 93568 and a handful of adjacent angiography codes not reviewed in over a decade, the societies undertook review of angiography codes 93563-93568 in addition to new codes 93569-93575. The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ-global day survey was completed by physicians who have experience with the services.

As we move through recommendations for this large group of codes, it is important to keep several elements in mind.

- The six existing codes **do not** include introduction of catheters; that work is billed separately as part of the catheterization code, so the existing codes should have lower values than the newly created codes.
- The new codes **do** include catheter placement as well as the injection and radiologic supervision and interpretation, reflecting more work as recommended in this submission.
- With maturation of technology and a larger congenital population to benefit from interventions, these services are now very commonly provided in the congenital population.
- Prior survey of the existing codes over a decade ago did not include a pool of pediatric interventional cardiologists who are typically treating a different patient population than what was captured in that survey. We believe that difference calls into question the ability to compare the times of the current survey with those of the prior survey.
- The expert panel finds the values for the new codes appropriate from a magnitude estimation perspective at the 25th-percentile work RVUs.
- It is not clear to the expert panel from the survey results that survey respondents understood the distinction that the existing codes **do not** include selective catheter placement while new codes **do** incorporate selective catheter placement as part of the service. Therefore, we are recommending the current values for the existing codes, despite the fact they are below the 25th-percentile of the survey. We identify no rationale to argue compelling evidence for higher work RVUs for the existing codes based on the survey results, nor are we aware of changes to these services from the past decade since prior evaluation.
- We believe these recommendations maintain/create a reasonable rank order with most of the existing codes falling below the new codes that more specifically define angiography in the arteries and pulmonary veins.

Survey Results

The key reference code is 36227 for selective catheter placement in the external carotid artery. It was selected by 24% of respondents. 50% of the respondents indicated that 93565 was of identical intensity/complexity, with the other half split between more and less intense/complex. The second reference code is 93561 for indicator dilution studies. It was selected by 24% of respondents, with a 63% of respondents indicating 93565 to be more intense/complex.

93565 Recommendation

The societies recommend the existing value of 0.86 work RVUs with 10 minutes intraservice time from the survey median. As noted above, this value falls below the survey 25th-percentile RVU. The expert panel believes this code and other current values for existing codes align with the recommended values at the 25th for the new codes. This value falls between MPC codes 64484 and 51797 that have times of 10 and 15 minutes, respectively with RVUs above and below the recommendation, as shown in the summary spreadsheet. This recommendation is also slightly higher than comparison code 15274 for 100 square centimeters of skin graft that also has 10 minutes intraservice time and a lower calculated intensity.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93565

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatric Interventional Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate not available

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 80 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare utilization data from 2019

Specialty cardiology Frequency 33 Percentage 41.25 %

Specialty pediatric interventional cardiology Frequency 28 Percentage 35.00 %

Specialty interventional cardiology Frequency 14 Percentage 17.50 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93565

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93566 Tracking Number P4 Original Specialty Recommended RVU: **0.86**
Presented Recommended RVU: **0.86**
Global Period: ZZZ Current Work RVU: **0.86** RUC Recommended RVU: **0.86**

CPT Descriptor: Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective right ventricular or right atrial angiography (list separately in addition to code for primary procedure) (use 93566 in conjunction with 93451, 93453, 93456, 93457, 93460, 93461, 93x1x, 93x2x, 93x3x, 93x4x, 93x5x, 93582) (do not report 93566 in conjunction with 33274 for right ventriculography performed during leadless pacemaker insertion) (do not report 93566 in conjunction with 0545t for right ventricular or right atrial angiography procedures intrinsic to the annulus reconstruction procedure)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient with tricuspid and mitral valve regurgitation has progressive dyspnea on exertion necessitating diagnostic heart catheterization (reported using 93460-93461or congenital cardiac catheterization codes 93530-93533) with additional contrast injection(s) for imaging for right ventriculogram/ atrial angiography. [Note: When completing this survey, only consider the "additional" physician work related to 93566.]

Percentage of Survey Respondents who found Vignette to be Typical: 82%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Diagnostic congenital or non-congenital catheterization codes include the work of passing a catheter into the right ventricle. The work of 93566 begins when the catheter is then attached to a power injector with careful removal of any air from the tubing. Fluoroscopic guidance is used to ensure proper catheter position. Power injection is then performed in appropriate angiographic views to fully opacify the ventricle, allowing evaluation of systolic function, competence of the tricuspid valve, ventriculo-arterial connection, and presence and location of any ventricular septal defects or outflow obstruction. The power injector is disconnected from the catheter, the catheter is reattached to the manifold, and any air is again removed. The patient's arterial pressure, electrocardiogram, and oxygen saturation are continuously monitored throughout the procedure. Images are reviewed and described in the procedure report. Per routine, any contrast injection is monitored afterward for complications of allergic reaction, arrhythmia, hemodynamic instability, and contrast-induced nephropathy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Mark Hoyer, MD; Ed Tuohy, MD					
Specialty Society(ies):	ACC & SCAI					
CPT Code:	93566					
Sample Size:	1373	**Resp N:**	34			
Description of Sample:	Adult and pediatric interventional cardiologists					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	4.00	30.00	**48.00**	100.00	300.00
Survey RVW:	2.00	5.00	**10.00**	20.00	50.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	5.00	**10.00**	20.00	50.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93566	**Recommended Physician Work RVU: 0.86**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93561	ZZZ	0.95	**RUC Time**

CPT Descriptor Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64484	ZZZ	1.00	**RUC Time**	431,178

CPT Descriptor 1 Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, each additional level (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
51797	ZZZ	0.80	**RUC Time**	116,064

CPT Descriptor 2 Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
15274	ZZZ	0.80	**RUC Time**

CPT Descriptor Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 29.4 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 20.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 93566	Top Key Reference CPT Code: 93561	2nd Key Reference CPT Code: 36227
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	10.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**10.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	10%	50%	20%	20%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	40%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	50%	30%

Physical effort required	10%	60%	30%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	10%	40%	50%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	29%	42%	29%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	28%	29%	43%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	43%	43%	14%
Physical effort required	29%	71%	

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	29%	42%	29%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Panel approved a proposal at the May meeting to create four new codes that accurately describe pulmonary angiography procedures as they are currently performed. Pulmonary angiography for patients with

congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. Existing CPT code 93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)* was created in the late 1990s to describe pulmonary angiography with congenital as well as non-congenital cardiac catheterization. Among its inadequacies, it fails to describe any difference between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code fails to capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient. Availability of only a single CPT code intended to capture these multiple injections was not sufficient and resulted in services being underdefined in CPT.

The CPT application sought to create the four new codes that would be used to report a significant portion—though not all—of the services now billed using 93568 and to make an editorial revision to 93568. With 93568 and a handful of adjacent angiography codes not reviewed in over a decade, the societies undertook review of angiography codes 93563-93568 in addition to new codes 93569-93575. The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ-global day survey was completed by physicians who have experience with the services.

As we move through recommendations for this large group of codes, it is important to keep several elements in mind.

- The six existing codes **do not** include introduction of catheters; that work is billed separately as part of the catheterization code, so the existing codes should have lower values than the newly created codes.
- The new codes **do** include catheter placement as well as the injection and radiologic supervision and interpretation, reflecting more work as recommended in this submission.
- With maturation of technology and a larger congenital population to benefit from interventions, these services are now very commonly provided in the congenital population.
- Prior survey of the existing codes over a decade ago did not include a pool of pediatric interventional cardiologists who are typically treating a different patient population than what was captured in that survey. We believe that difference calls into question the ability to compare the times of the current survey with those of the prior survey.
- The expert panel finds the values for the new codes appropriate from a magnitude estimation perspective at the 25th-percentile work RVUs.
- It is not clear to the expert panel from the survey results that survey respondents understood the distinction that the existing codes **do not** include selective catheter placement while new codes **do** incorporate selective catheter placement as part of the service. Therefore, we are recommending the current values for the existing codes, despite the fact they are below the 25th-percentile of the survey. We identify no rationale to argue compelling evidence for higher work RVUs for the existing codes based on the survey results, nor are we aware of changes to these services from the past decade since prior evaluation.
- We believe these recommendations maintain/create a reasonable rank order with most of the existing codes falling below the new codes that more specifically define angiography in the arteries and pulmonary veins.

Survey Results

The key reference code is 93561 for indicator dilution studies. It was selected by 29% of respondents, with 50% of respondents indicating 93566 as similarly intense/complex and 40% indicating it is more intense/complex. The second reference code 36227 for selective catheter placement in the external carotid artery. It was selected by 21% of respondents. 42% of the respondents indicated that 93566 was of similar intensity/complexity, with the remainder split between more and less intense/complex.

93566 Recommendation

The societies recommend the existing value of 0.86 work RVUs with 10 minutes intraservice time from the survey median. As noted above, this value falls below the survey 25th-percentile RVU. The expert panel believes this code and other current values for existing codes align with the recommended values at the 25th for the new codes. This value falls between MPC codes 64484 and 51797 that have times of 10 and 15 minutes, respectively with RVUs above and below the recommendation, as shown in the summary spreadsheet. This recommendation is also slightly higher than comparison code 15274 for 100 square centimeters of skin graft that also has 10 minutes intraservice time with a slightly a lower RVU and calculated intensity.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93566

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Internventional Cardiology How often? Sometimes

Specialty Pediatric Interventional Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Commercial estimate not available.

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 388
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization

Specialty Cardiology Frequency 265 Percentage 68.29 %

Specialty Interventional Cardiology Frequency 40 Percentage 10.30 %

Specialty Pediatric Interventional Cardiology Frequency 60 Percentage 15.46 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93566

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93567 Tracking Number P5 Original Specialty Recommended RVU: **0.97**
Presented Recommended RVU: **0.97**
Global Period: ZZZ Current Work RVU: **0.97** RUC Recommended RVU: **0.97**

CPT Descriptor: injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for supravalvular aortography (list separately in addition to code for primary procedure) (use 93567 in conjunction with 93451-93461,93x1x, 93x2x, 93x3x, 93x4x, 93x5x) (for non-supravalvular thoracic aortography or abdominal aortography performed at the time of cardiac catheterization, use the appropriate radiological supervision and interpretation codes [36221, 75600-75630])

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A patient undergoing diagnostic heart catheterization (reported using codes 93460-93461, 93530-93533) with clinical evidence of disease of the aorta or one of its major branches (eg, aneurysm, dissection, obstruction) or disease of the aortic valve. (Note: Code 93657 is an add-on code and only the additional physician work should be reported for this code.)

Percentage of Survey Respondents who found Vignette to be Typical: 100%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Diagnostic congenital or non-congenital catheterization codes include the work of passing a catheter into the aorta. The work of 93567 begins when the catheter is then attached to a power injector with careful removal of air from the tubing. Fluoroscopic guidance is used to ensure proper catheter position. Power injection is then performed in appropriate angiographic views to fully opacify the aorta, allowing evaluation of aortic valve regurgitation, arch-sidedness, arch vessels, presence of coarctation or patent ductus arteriosus, and other aortic abnormalities. The power injector is disconnected from the catheter, the catheter is reattached to the manifold, and any air is again removed. The patient's arterial pressure, electrocardiogram, and oxygen saturation are continuously monitored throughout the procedure. Images are reviewed and described in the procedure report. Per routine, any contrast injection is monitored afterward for complications of allergic reaction, arrhythmia, hemodynamic instability, and contrast-induced nephropathy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Mark Hoyer, MD; Ed Tuohy, MD					
Specialty Society(ies):	ACC & SCAI					
CPT Code:	93567					
Sample Size:	1373	**Resp N:**	34			
Description of Sample:	Adult and pediatric interventional cardiologists					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	2.00	10.00	**55.00**	75.00	300.00	
Survey RVW:	0.52	0.99	**1.35**	1.95	6.00	
Pre-Service Evaluation Time:			**0.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	2.00	5.00	**10.00**	20.00	90.00	
Immediate Post Service-Time:	**0.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93567	**Recommended Physician Work RVU: 0.97**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**10.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93562	ZZZ	0.77	**RUC Time**

CPT Descriptor Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; subsequent measurement of cardiac output

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
52442	ZZZ	1.01	**RUC Time**	101,717

CPT Descriptor 1 Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64484	ZZZ	1.00	**RUC Time**	431,178

CPT Descriptor 2 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedur

Other Reference CPT Code	Global	Work RVU	Time Source
93572	ZZZ	1.00	**RUC Time**

CPT Descriptor Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 8 **% of respondents:** 23.5 **%**

Number of respondents who choose 2nd Key Reference Code: 7 **% of respondents:** 20.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 93567	Top Key Reference CPT Code: 93562	2nd Key Reference CPT Code: 36227
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	15.00	12.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**15.00**	**12.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	75%	13%	12%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	75%	25%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	75%	25%
Physical effort required	0%	75%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	88%	12%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	14%	43%	43%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	71%	29%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	29%	71%	0%
Physical effort required	14%	72%	14%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	71%	29%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Panel approved a proposal at the May meeting to create four new codes that accurately describe pulmonary angiography procedures as they are currently performed. Pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. Existing CPT code 93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)* was created in the late 1990s to describe pulmonary angiography with congenital as well as non-congenital cardiac catheterization. Among its inadequacies, it fails to describe any difference between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code fails to capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient. Availability of only a single CPT code intended to capture these multiple injections was not sufficient and resulted in services being underdefined in CPT.

The CPT application sought to create the four new codes that would be used to report a significant portion—though not all—of the services now billed using 93568 and to make an editorial revision to 93568. With 93568 and a handful of adjacent angiography codes not reviewed in over a decade, the societies undertook review of angiography codes 93563-93568 in addition to new codes 93569-93575. The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ-global day survey was completed by physicians who have experience with the services.

As we move through recommendations for this large group of codes, it is important to keep several elements in mind.

- The six existing codes **do not** include introduction of catheters; that work is billed separately as part of the catheterization code, so the existing codes should have lower values than the newly created codes.
- The new codes **do** include catheter placement as well as the injection and radiologic supervision and interpretation, reflecting more work as recommended in this submission.
- With maturation of technology and a larger congenital population to benefit from interventions, these services are now very commonly provided in the congenital population.
- Prior survey of the existing codes over a decade ago did not include a pool of pediatric interventional cardiologists who are typically treating a different patient population than what was captured in that survey. We believe that difference calls into question the ability to compare the times of the current survey with those of the prior survey.
- The expert panel finds the values for the new codes appropriate from a magnitude estimation perspective at the 25th-percentile work RVUs.
- It is not clear to the expert panel from the survey results that survey respondents understood the distinction that the existing codes **do not** include selective catheter placement while new codes **do** incorporate selective catheter placement as part of the service. Therefore, we are recommending the current values for the existing codes, despite the fact they are below the 25th-percentile of the survey. We identify no rationale to argue compelling evidence for higher work RVUs for the existing codes based on the survey results, nor are we aware of changes to these services from the past decade since prior evaluation.
- We believe these recommendations maintain/create a reasonable rank order with most of the existing codes falling below the new codes that more specifically define angiography in the arteries and pulmonary veins.

Survey Results

The key reference code is 93562 for indicator dilution studies. It was selected by 24% of respondents, with 75% of respondents indicating 93567 as similarly intense/complex and 25% indicating it is more intense/complex. The second reference code 36227 for selective catheter placement in the external carotid artery. It was selected by 21% of respondents. 43% of the respondents indicated that 93567 was of similar intensity/complexity and 43% said it was more intense/complex.

93567 Recommendation

The societies recommend the existing value of 0.97 work RVUs with 10 minutes intraservice time from the survey median. As noted above, this value falls below the survey 25th-percentile RVU. The expert panel believes this code and other current values for existing codes align with the recommended values at the 25th for the new codes. This value falls between MPC codes 64484 and 52442 that have times of 10 and 15 minutes, respectively with RVUs above and below the recommendation, as shown in the summary spreadsheet. This recommendation is also slightly lower than comparison code 93572 for intravascular Doppler and/or pressure flow reserve measurement with a slightly longer 11 minutes intraservice time with a slightly a higher RVU.

It was noted by reviewers that an explanation for why this service would have slightly RVU but identical time to previous codes 93566 and 93567 would be helpful. We believe this outcome can reasonably be explained by the fact that this service is typically provided to sick adult patients. There is a greater risk of rupture and catheter passes are more tortuous in the senior population. We likely see a calcified aorta, and there is risk of dislocation of aortic plaque. Finally, when working in the aorta, care must be taken to avoid introduction of air into the vasculature where it would be iatrogenic.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93567

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatric Interventional Cardology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Commercial estimate not avaialable

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 28,640 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare utilization

Specialty Cardiology Frequency 18500 Percentage 64.59 %

Specialty Interventional Cardiology Frequency 9200 Percentage 32.12 %

Specialty Pediatric Interventional Cardiology Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:
Major procedure

BETOS Sub-classification Level II:
Cardiovascular-Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93567

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:93568 Tracking Number P6 Original Specialty Recommended RVU: **0.88**
Presented Recommended RVU: **0.88**
Global Period: ZZZ Current Work RVU: **0.88** RUC Recommended RVU: **0.88**

CPT Descriptor: Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for nonselective pulmonary arterial angiography (list separately in addition to code for primary procedure) (use 93568 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, 338x1, 338x2, 338x3, 338x4, 338x5, 338x6, 338x7, 37187, 37188, 37236, 37237, 37238, 37246, 37248, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, 93x1x, 93x2x, 93x3x, 93x4x, 93x5x, 93580, 93581, 93582, 93583) (for selective unilateral or bilateral pulmonary arterial angiography, use 93xx0, 93xx1, which include catheter placement, injection, and radiologic supervision and interpretation)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: During a diagnostic cardiac catheterization, a 40-year-old female with dyspnea and echocardiographic findings of a dilated right ventricle undergoes a diagnostic right heart catheterization. During the procedure, nonselective pulmonary arterial angiography is performed. Note: This is an add-on service. Only consider the additional work related to the nonselective pulmonary artery angiogram.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Diagnostic congenital or non-congenital catheterization codes include the work of passing a catheter into the main pulmonary artery. The work of 93568 begins when the catheter is then attached to a power injector with careful removal of air from the tubing. Fluoroscopic guidance is used to ensure proper catheter position. Power injection is then performed in appropriate angiographic views to fully opacify the pulmonary artery, allowing evaluation of pulmonary valve regurgitation, branch pulmonary blood flow, and other vessel abnormalities. The power injector is disconnected from the catheter, the catheter is reattached to the manifold, and any air is again removed. The patient's arterial pressure, electrocardiogram, and oxygen saturation are continuously monitored throughout the procedure. All images are reviewed and described in the procedure report. Per routine, any contrast injection is monitored afterward for complications of allergic reaction, arrhythmia, hemodynamic instability, and contrast-induced nephropathy.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Thad Waites, MD; Edward Toggart, MD; Mark Hoyer, MD; Ed Tuohy					
Specialty Society(ies):	ACC & SCAI					
CPT Code:	93568					
Sample Size:	1373	**Resp N:**	35			
Description of Sample:	Adult and pediatric interventional cardiologists					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	12.00	30.00	**50.00**	70.00	500.00
Survey RVW:	0.53	0.98	**1.80**	2.17	9.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	7.00	**13.00**	20.00	90.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	93568	**Recommended Physician Work RVU: 0.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**13.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

ZZZ Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
36227	ZZZ	2.09	**RUC Time**

CPT Descriptor Selective catheter placement, external carotid artery, unilateral, with angiography of the ipsilateral external carotid circulation and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
93561	ZZZ	0.95	**RUC Time**

CPT Descriptor Indicator dilution studies such as dye or thermodilution, including arterial and/or venous catheterization; with cardiac output measurement (separate procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
64484	ZZZ	1.00	**RUC Time**	431,178

CPT Descriptor 1 Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel (List separately in addition to code for primary procedure

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
51797	ZZZ	0.80	**RUC Time**	116,064

CPT Descriptor 2 Voiding pressure studies, intra-abdominal (ie, rectal, gastric, intraperitoneal) (List separately in addition to code for primary procedure)

Other Reference CPT Code	Global	Work RVU	Time Source
15274	ZZZ	0.80	**RUC Time**

CPT Descriptor Application of skin substitute graft to trunk, arms, legs, total wound surface area greater than or equal to 100 sq cm; each additional 100 sq cm wound surface area, or part thereof, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 10 **% of respondents:** 28.5 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 22.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 93568	Top Key Reference CPT Code: 36227	2nd Key Reference CPT Code: **93561**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	13.00	15.00	15.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**13.00**	**15.00**	**15.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	10%	40%	50%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	20%	10%	70%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	30%	50%
Physical effort required	20%	40%	40%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	60%	20%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	50%	25%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	25%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	37%	63%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	50%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Panel approved a proposal at the May meeting to create four new codes that accurately describe pulmonary angiography procedures as they are currently performed. Pulmonary angiography for patients with congenital heart defects is a complex mix of services with only a single existing CPT code which fails to capture the variability encountered. Existing CPT code 93568 *Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for pulmonary angiography (List separately in addition to code for primary procedure)* was created in the late 1990s to describe pulmonary angiography with congenital as well as non-congenital cardiac catheterization. Among its inadequacies, it fails to describe any difference between pulmonary arterial and pulmonary venous, two completely different structures; the former a right heart structure, and the latter, left heart. Furthermore, this code fails to capture the variety of different approaches to pulmonary arterial angiography for congenital heart disease, such as approaching from the venous system, across right heart structures, as compared to pulmonary arteries originating from the arterial system, or in many cases, when both exist in the same patient. Availability of only a single CPT code intended to capture these multiple injections was not sufficient and resulted in services being underdefined in CPT.

The CPT application sought to create the four new codes that would be used to report a significant portion—though not all—of the services now billed using 93568 and to make an editorial revision to 93568. With 93568 and a handful of adjacent angiography codes not reviewed in over a decade, the societies undertook review of angiography codes 93563-93568 in addition to new codes 93569-93575. The ACC and SCAI randomly surveyed interventional cardiologists and pediatric interventional cardiologists, as designated by membership rolls, on the newly created codes. The ZZZ-global day survey was completed by physicians who have experience with the services.

As we move through recommendations for this large group of codes, it is important to keep several elements in mind.

- The six existing codes **do not** include introduction of catheters; that work is billed separately as part of the catheterization code, so the existing codes should have lower values than the newly created codes.
- The new codes **do** include catheter placement as well as the injection and radiologic supervision and interpretation, reflecting more work as recommended in this submission.
- With maturation of technology and a larger congenital population to benefit from interventions, these services are now very commonly provided in the congenital population.
- Prior survey of the existing codes over a decade ago did not include a pool of pediatric interventional cardiologists who are typically treating a different patient population than what was captured in that survey. We believe that difference calls into question the ability to compare the times of the current survey with those of the prior survey.
- The expert panel finds the values for the new codes appropriate from a magnitude estimation perspective at the 25th-percentile work RVUs.
- It is not clear to the expert panel from the survey results that survey respondents understood the distinction that the existing codes **do not** include selective catheter placement while new codes **do** incorporate selective catheter placement as part of the service. Therefore, we are recommending the current values for the existing codes, despite the fact they are below the 25th-percentile of the survey. We identify no rationale to argue compelling evidence for higher work RVUs for the existing codes based on the survey results, nor are we aware of changes to these services from the past decade since prior evaluation.
- We believe these recommendations maintain/create a reasonable rank order with most of the existing codes falling below the new codes that more specifically define angiography in the arteries and pulmonary veins.

Survey Results

The key reference code is 36227 for selective catheter placement in the external carotid artery. It was selected by 29% of respondents. 50% of the respondents indicated that 93568 was of more intense/complex, while 40%

indicated it was similarly intense/complex. The second reference code is 93561 for indicator dilution studies. It was selected by 23% of respondents. 50% of respondents indicating 93568 to be more intense/complex and 50% said it was similarly intense/complex.

93568 Recommendation

The societies recommend the existing value of 0.88 work RVUs with 13 minutes intraservice time from the survey median. As noted above, this value falls below the survey 25th-percentile RVU. The expert panel believes this code and other current values for existing codes align with the recommended values at the 25th for the new codes. This value falls between MPC codes 64484 and 51797 that have times of 10 and 15 minutes, respectively with RVUs above and below the recommendation, as shown in the summary spreadsheet. This recommendation is also slightly higher than comparison code 15274 for 100 square centimeters of skin graft that has 10 minutes intraservice time with a slightly a lower RVU.

It was noted by reviewers that an explanation for why this service would have slightly more time but a slightly lower RVU than previous code 93567 would be helpful. We believe this outcome can reasonably be explained by the fact that it takes more time to navigate the catheter around the right ventricle. That effort is not as difficult/intense as what we just described for 93567 with a typically older, tortuous, calcified landscape. However, it does take some time to advance the catheter through two valves to get into position.

It was noted by reviewers that an explanation for

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 93568

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Cardiology How often? Sometimes

Specialty Interventional Cardiology How often? Sometimes

Specialty Pediatric Interventional Cardiology How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 0
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Commercial estimate unavailable

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 400
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 30% of 2019 93568 utilization, as we predict 70% of the utilization to move to codes 93569-93575

Specialty Cardiology Frequency 225 Percentage 56.25 %

Specialty Interventional Cardiology Frequency 110 Percentage 27.50 %

Specialty Pediatric Interventional Cardiology Frequency 40 Percentage 10.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Procedures

BETOS Sub-classification:

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 93568

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

ISSUE: Pulmonary Angiography

TAB: 8

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	36227	ZZZ	Selective catheter placement, external carotid artery,	2010	16	0.139	0.139			2.09			15						15								
2nd REF	93571	ZZZ	Intravascular Doppler velocity and/or pressure derived	2010	5	0.092	0.092			1.38			15						15								
CURRENT	93563	ZZZ	Injection procedure during cardiac catheterization	2010		0.044	0.044			1.11			25						25								
SVY	93563	ZZZ	Injection procedure during cardiac catheterization		35	0.133	0.133	0.70	1.32	2.00	2.20	6.00	15				4	10	15	24	90		1	12	25	50	125
REC	93563	ZZZ	Injection procedure during cardiac catheterization			0.074	0.074			1.11			15						15								
MPC	64480	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; transforaminal	2009		0.080	0.080			1.20			15						15								
MPC	52442	ZZZ	Cystourethroscopy, with insertion of permanent	2019		0.067	0.067			1.01			15						15								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	36227	ZZZ	Selective catheter placement, external carotid artery,	2010	14	0.139	0.139			2.09			15						15								
2nd REF	93571	ZZZ	Intravascular Doppler velocity and/or pressure derived	2010	4	0.092	0.092			1.38			15						15								
CURRENT	93564	ZZZ	Injection procedure during cardiac catheterization	2010		0.045	0.045			1.13			25						25								
SVY	93564	ZZZ	Injection procedure during cardiac catheterization		25	0.122	0.122	1.00	1.67	2.20	2.40	7.00	18				5	12	18	25	120		0	0	2	5	50
REC	93564	ZZZ	Injection procedure during cardiac catheterization			0.063	0.063			1.13			18						18								
MPC	64480	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; transforaminal	2009		0.080	0.080			1.20			15						15								
MPC	52442	ZZZ	Cystourethroscopy, with insertion of permanent	2019		0.067	0.067			1.01			15						15								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	36227	ZZZ	Selective catheter placement, external carotid artery,	2010	8	0.139	0.139			2.09			15						15								
2nd REF	93561	ZZZ	Indicator dilution studies such as dye or thermodilution,	2018	8	0.063	0.063			0.95			15						15								
CURRENT	93565	ZZZ	Injection procedure during cardiac catheterization	2010		0.043	0.043			0.86			20						20								
SVY	93565	ZZZ	Injection procedure during cardiac catheterization		35	0.125	0.125	0.63	1.00	1.25	2.05	8.00	10				2	7	10	20	60		6	20	45	83	200
REC	93565	ZZZ	Injection procedure during cardiac catheterization			0.086	0.086			0.86			10						10								
MPC	64484	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; transforaminal	2009		0.100	0.100			1.00			10						10								
MPC	51797	ZZZ	Voiding pressure studies, intra-abdominal (ie, rectal, gastric,	2007		0.053	0.053			0.80			15						15								
COMP	15274	ZZZ	Application of skin substitute graft to trunk, arms, legs, total	2011		0.080	0.080			0.80			10						10								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93561	ZZZ	Indicator dilution studies such as dye or thermodilution,	2018	10	0.063	0.063			0.95			15						15								
2nd REF	36227	ZZZ	Selective catheter placement, external carotid artery,	2010	7	0.139	0.139			2.09			15						15								
CURRENT	93566	ZZZ	Injection procedure during cardiac catheterization	2010		0.043	0.043			0.86			20						20								
SVY	93566	ZZZ	Injection procedure during cardiac catheterization		34	0.113	0.113	0.58	0.93	1.13	2.07	8.00	10				2	5	10	20	50		4	30	48	100	300
REC	93566	ZZZ	Injection procedure during cardiac catheterization			0.086	0.086			0.86			10						10								
MPC	64484	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; transforaminal	2009		0.100	0.100			1.00			10						10								
MPC	51797	ZZZ	Voiding pressure studies, intra-abdominal (ie, rectal, gastric,	2007		0.053	0.053			0.80			15						15								
COMP	15274	ZZZ	Application of skin substitute graft to trunk, arms, legs, total	2011		0.080	0.080			0.80			10						10								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	93562	ZZZ	Indicator dilution studies such as dye or thermodilution,	2018	8	0.064	0.064			0.77			12						12								
2nd REF	36227	ZZZ	Selective catheter placement, external carotid artery,	2010	7	0.139	0.139			2.09			15						15								
CURRENT	93567	ZZZ	Injection procedure during cardiac catheterization	2010		0.065	0.065			0.97			15						15								
SVY	93567	ZZZ	injection procedure during cardiac catheterization		34	0.135	0.135	0.52	0.99	1.35	1.95	6.00	10				2	5	10	20	90		2	10	55	75	300
REC	93567	ZZZ	Injection procedure during cardiac catheterization			0.097	0.097			0.97			10						10								
MPC	52442	ZZZ	Cystourethroscopy, with insertion of permanent	2019		0.067	0.067			1.01			15						15								
MPC	64484	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; transforaminal	2009		0.100	0.100			1.00			10						10								
COMP	93572	ZZZ	Intravascular Doppler velocity and/or pressure derived	2017		0.091	0.091			1.00			11						11								

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	36227	ZZZ	Selective catheter placement, external carotid artery,	2010	10	0.139	0.139			2.09			15						15								
2nd REF	93561	ZZZ	Indicator dilution studies such as dye or thermodilution,	2018	8	0.063	0.063			0.95			15						15								
CURRENT	93568	ZZZ	Injection procedure during cardiac catheterization	2010		0.044	0.044			0.88			20						20								
SVY	93568	ZZZ	Injection procedure during cardiac catheterization		35	0.138	0.138	0.53	0.98	1.80	2.17	9.00	13				3	7	13	20	90		12	30	50	70	500
REC	93568	ZZZ	Injection procedure during cardiac catheterization			0.068	0.068			0.88			13						13								

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
16					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
17	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
77	MPC	64484	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; transforaminal	2009		0.100	0.100			1.00			10						10								
78	MPC	51797	ZZZ	Voiding pressure studies, intra-abdominal (ie, rectal, gastric,	2007		0.053	0.053			0.80			15						15								
79	COMP	15274	ZZZ	Application of skin substitute graft to trunk, arms, legs, total	2011		0.080	0.080			0.80			10						10								
80																												
81					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
82	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
83	1st REF	36227	ZZZ	Selective catheter placement, external carotid artery,	2010	9	0.139	0.139			2.09			15						15								
84	2nd REF	93561	ZZZ	Indicator dilution studies such as dye or thermodilution,	2018	5	0.063	0.063			0.95			15						15								
85	SVY	93569	ZZZ	injection procedure during cardiac catheterization		32	0.168	0.168	0.43	1.05	1.85	2.33	9.00	11				4	8	11	21	50		10	24	40	50	500
86	REC	93569	ZZZ	Injection procedure during cardiac catheterization			0.095	0.095			1.05			11						11								
87	MPC	64484	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; transforaminal	2009		0.100	0.100			1.00			10						10								
88	MPC	64480	ZZZ	Injection(s), anesthetic agent(s) and/or steroid; transforaminal	2009		0.080	0.080			1.20			15						15								
89																												
90					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
91	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
92	1st REF	36227	ZZZ	Selective catheter placement, external carotid artery,	2010	9	0.139	0.139			2.09			15						15								
93	2nd REF	93561	ZZZ	Indicator dilution studies such as dye or thermodilution,	2018	5	0.063	0.063			0.95			15						15								
94	SVY	93573	ZZZ	injection procedure during cardiac catheterization		33	0.118	0.118	0.65	1.75	2.12	2.50	10.00	18				5	12	18	30	110		5	25	30	50	300
95	REC	93573	ZZZ	injection procedure during cardiac catheterization			0.097	0.097			1.75			18						18								
96	MPC	37253	ZZZ	Intravascular ultrasound (noncoronary vessel) during	2018		0.071	0.069			1.44			21						20			1					
97	MPC	99292	ZZZ	Critical care, evaluation and management of the critically ill	2005		0.075	0.075			2.25			30						30								
98	COMP	36483	ZZZ	Endovenous ablation therapy of incompetent vein, extremity,	2017		0.088	0.088			1.75			20						20								
99																												
100					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
101	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
102	1st REF	36227	ZZZ	Selective catheter placement, external carotid artery,	2010	12	0.139	0.139			2.09			15						15								
103	2nd REF	92978	ZZZ	Endoluminal imaging of coronary vessel or graft using	1996	5	0.072	0.072			1.80			25						25								
104	SVY	93574	ZZZ	injection procedure during cardiac catheterization		32	0.122	0.122	0.58	1.84	2.43	3.00	10.00	20				5	10	20	26	80		4	10	20	40	200
105	REC	93574	ZZZ	injection procedure during cardiac catheterization			0.092	0.092			1.84			20						20								
106	MPC	37253	ZZZ	Intravascular ultrasound (noncoronary vessel) during	2018		0.071	0.069			1.44			21						20			1					
107	MPC	99292	ZZZ	Critical care, evaluation and management of the critically ill	2005		0.075	0.075			2.25			30						30								
108	COMP	36483	ZZZ	Endovenous ablation therapy of incompetent vein, extremity,	2017		0.088	0.088			1.75			20						20								
109																												
110					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
111	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
112	1st REF	36227	ZZZ	Selective catheter placement, external carotid artery,	2010	15	0.139	0.139			2.09			15						15								
113	2nd REF	92973	ZZZ	Percutaneous transluminal coronary thrombectomy (List	2001	4	0.082	0.082			3.28			40						40								
114	SVY	93575	ZZZ	Injection procedure during cardiac catheterization		33	0.118	0.118	0.46	1.92	2.35	3.10	10.00	20				5	10	20	31	120		0	5	9	15	100
115	REC	93575	ZZZ	Injection procedure during cardiac catheterization			0.096	0.096			1.92			20						20								
116	MPC	37253	ZZZ	Intravascular ultrasound (noncoronary vessel) during	2018		0.071	0.069			1.44			21						20			1					
117	MPC	99292	ZZZ	Critical care, evaluation and management of the critically ill	2005		0.075	0.075			2.25			30						30								
118	COMP	36483	ZZZ	Endovenous ablation therapy of incompetent vein, extremity,	2017		0.088	0.088			1.75			20						20								

Journal of the American Heart Association

ORIGINAL RESEARCH

Angiographic Anatomy of Major Aortopulmonary Collateral Arteries and Association With Early Surgical Outcomes in Tetralogy of Fallot

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BACKGROUND: Due in part to the heterogeneity of the pulmonary circulation in patients with tetralogy of Fallot and major aortopulmonary collateral arteries (MAPCAs), research on this condition has focused on relatively basic anatomic characteristics. We aimed to detail pulmonary artery (PA) and MAPCA anatomy in a large group of infants, assess relationships between anatomy and early surgical outcomes, and consider systems for classifying MAPCAs.

METHODS AND RESULTS: All infants (<1 year of age) undergoing first cardiac surgery for tetralogy of Fallot/MAPCAs from 2001 to 2019 at Stanford University were identified. Preoperative angiograms delineating supply to all 18 pulmonary segments were reviewed for details of each MAPCA and the arborization and size of central PAs. We studied 276 patients with 1068 MAPCAs and the following PA patterns: 152 (55%) incompletely arborizing PAs, 48 (17%) normally arborizing PAs, 45 (16%) absent PAs, and 31 (11%) unilateral MAPCAs. There was extensive anatomic variability, but no difference in early outcomes according to PA arborization or the predominance of PAs or MAPCAs. Patients with low total MAPCA and/or PA cross-sectional area were less likely to undergo complete repair.

CONCLUSIONS: MAPCA anatomy is highly variable and essentially unique for each patient. Though each pulmonary segment can be supplied by a MAPCA, central PA, or both, all anatomic combinations are similarly conducive to a good repair. Total cross-sectional area of central PA and MAPCA material is an important driver of outcome. We elucidate a number of novel associations between anatomic features, but the extreme variability of the pulmonary circulation makes a granular tetralogy of Fallot/MAPCA classification system unrealistic.

Key Words: catheterization ■ DiGeorge syndrome ■ major aortopulmonary collateral arteries ■ pulmonary artery ■ pulmonary atresia ■ tetralogy of Fallot

The complexity of managing patients with tetralogy of Fallot (TOF) and major aortopulmonary collateral arteries (MAPCAs) revolves around the anatomy and function of the pulmonary circulation. Each of the 18 bronchopulmonary segments can be supplied by MAPCAs, central pulmonary artery (PA), or both, with variable location and severity of stenoses.[1] While the spectrum of MAPCA and PA anatomy is generally recognized, there has been no large or comprehensive evaluation of pulmonary vascular anatomy in a clinical cohort with this condition. Because of the challenge of defining and evaluating this variability, the literature on this condition has typically included limited anatomic information related to the pulmonary circulation, such as the presence or absence of intrapericardial PAs, the number of MAPCAs, and/or the number of lung

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CLINICAL PERSPECTIVE

What Is New?

- We provide novel insight into the distribution and constellation of anatomic features in infants with tetralogy of Fallot and major aortopulmonary collateral arteries (MAPCAs).
- The distribution of MAPCAs were essentially unique for each patient, making a universal classification scheme unrealistic.
- A predominance of MAPCAs versus central pulmonary arteries, as measured both by cross-sectional area and by number of lung segments supplied, was not associated with early outcomes.

What Are the Clinical Implications?

- Anatomic associations revealed in this work can guide the preoperative evaluation and surgical approach when managing infants with MAPCAs.
- Using a strategy of early complete unifocalization, a good early surgical result can be achieved for essentially any anatomic variation.
- Less total cross-sectional area of usable native MAPCA and pulmonary artery material portends a worse outcome.

Nonstandard Abbreviations and Acronyms

MAPCAs	major aortopulmonary collateral arteries
TNPAI	total neo-pulmonary artery index

segments connected to the central PAs.[2–11] Although we recently reported outcomes in a large cohort of patients with TOF/MAPCAs,[3] we have not analyzed patients according to more detailed anatomic features of the pulmonary circulation. However, we suspect that there are important anatomic aspects that can be elucidated via detailed characterization of the pulmonary circulation. The aims of this study were to detail the PA and MAPCA anatomy in a large group of infants, assess relationships between anatomic variables and early outcomes, and consider systems for classifying patients with MAPCAs in an effort to improve communication, facilitate understanding of risk factors and outcomes, and define subgroups to enhance collaboration and clinical and translational research.

METHODS

The data that support the findings of this study are available from the corresponding author upon reasonable request. This study was approved by the Stanford University Institutional Review Board (Protocol 56280) with a waiver of consent.

Patients

With approval from the Stanford University Institutional Review Board (Protocol 56280), all patients with TOF/MAPCAs undergoing cardiac surgery at Lucile Packard Children's Hospital between November 2001 and August 2019 were identified. Patients were included in this study if preoperative angiograms were available that clearly and completely delineated the native MAPCA and PA anatomy as well as the blood supply to all 18 bronchopulmonary segments. Patients >1 year of age at catheterization were excluded given that MAPCAs left in a native state for a prolonged period can become atretic, and untreated older children may develop acquired collaterals to the pulmonary circulation, both of which can obscure understanding of the native anatomy.

Characterization of MAPCAs

MAPCAs were characterized angiographically according to number, origin, course, and segmental supply, as well as the location of any connection to the central, branch, or lobar PAs (Table S1).

Number

Although MAPCAs can be quantified in several ways, for this anatomic study a vessel was counted if it had an identifiable origin from the systemic circulation. A vessel with a common trunk before branching was counted as a single MAPCA with branches, whereas if no common trunk was seen, branches arising from the same site were counted as separate MAPCAs. This is different from our surgical definition[1] where each branch requiring unifocalization is counted separately.

Origin

Origins were identified as left or right subclavian artery (SCA) (including branches thereof), transverse aorta, descending thoracic aorta, abdominal aorta (at or below the level of the diaphragm), or coronary artery. The presence of a unilateral ductus arteriosus (PDA) or an anomalous PA from the ascending aorta were also documented.

Course

The course of a MAPCA was characterized based on its insertion into the lung parenchyma: leftward (into the left PA), rightward (into the right PA), bilateral (branches to right and left PA), or midline (into the intrapericardial PA).

Nature of supply

Each MAPCA was classified as (1) single-supply (MAPCA serves as the only source of blood flow to the lung segment[s]), with no connection to a central PA, (2) isolated supply to central PAs (the only MAPCA connecting to the central PAs; (3) dual-supply (1 of ≥2 MAPCAs connecting to the central PAs); or (4) mixed-supply (≥1 single-supply and ≥1 dual-supply branches), as demonstrated in Figures 1 and 2.

Unilateral PDA

A unilateral PDA was defined as a patent or involuted vessel arising from the typical location of a PDA (ie, the isthmus or the innominate artery, depending on arch laterality and branching) and supplying a normally arborizing PA, with no MAPCAs to that lung and no intrapericardial PA (Figure 1). Based on our understanding that a PDA and single-supply collaterals should not supply the same lung, and on the observation that the recurrent laryngeal nerve was not anatomically associated with any such vessel on intraoperative inspection, a vessel arising from the same general location as a PDA but supplying only part of 1 or both PAs was considered a MAPCA (Figure 1).

Angiogram Review

Angiograms were reviewed offline by 2 investigators (G.T.A., S.B.P.) masked to clinical details. MAPCAs and PA characteristics were recorded, along with aortic arch sidedness and branching, and coronary anatomy. When present, the proximal intrapericardial PAs were measured in the anteroposterior projection and the average of left and right PAs reported. Because intrapulmonary PAs are often larger than intrapericardial PAs in TOF/MAPCAs (Figure 2), PA diameters were also measured at the first lobar bifurcation in the anteroposterior projection and used to calculate a modified Nakata index, with the assumption of circular cross-section.[12] Single-supply MAPCAs were measured distal to the likely unifocalization site, beyond any central, lobar, and segmental stenoses (Figure 2). The sum of the cross-sectional areas of single-supply MAPCAs and single-supply branches from mixed-supply MAPCAs (Figures 1 and 2) was defined as the MAPCA index. If a single supply MAPCA branch arose proximal

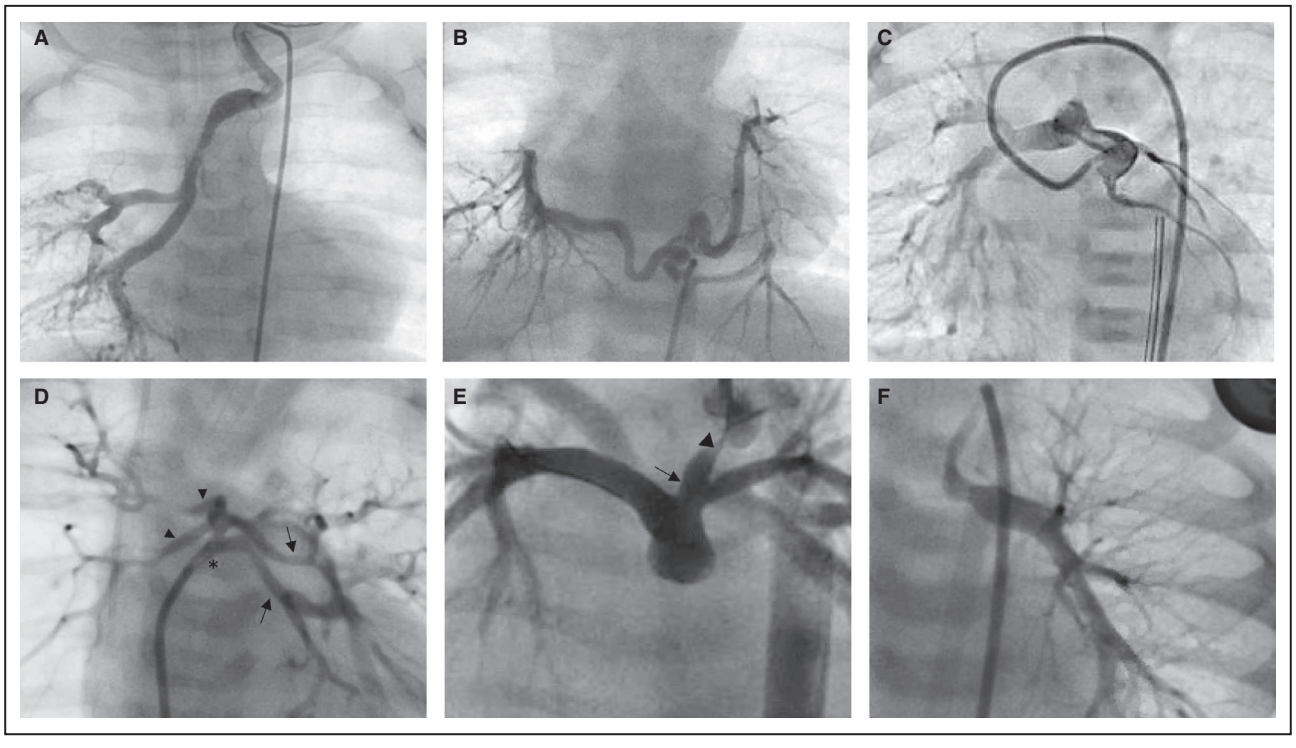

Figure 1. Examples of major aortopulmonary collateral arteries (MAPCA) and a ductus arteriosus in 6 different patients. **A**, Single-supply MAPCA arising from the left subclavian artery and coursing rightward to provide sole supply to a portion of the right lower pulmonary artery (PA). **B**, Abdominal aorta MAPCA giving 2 dual-supply branches, 1 to the right intermediate and 1 to the left PA. **C**, Coronary MAPCA arising from a dilated left main coronary, inserting in the intrapericardial main PA and supplying a normally arborizing right PA. **D**, Mixed-supply MAPCA with a common trunk (*) and multiple branches; 2 (arrow) connect to a central left PA, and 2 (arrowheads) are single-supply to portions of the right PA. **E**, MAPCA with origin (arrowhead) and insertion (arrow) consistent with a ductus arteriosus, but supplying incompletely arborizing intrapericardial PAs, with 10 segments supplied by single-supply MAPCAs. **F**, Prostaglandin-sensitive ductus arteriosus supplying a normally arborizing left PA.

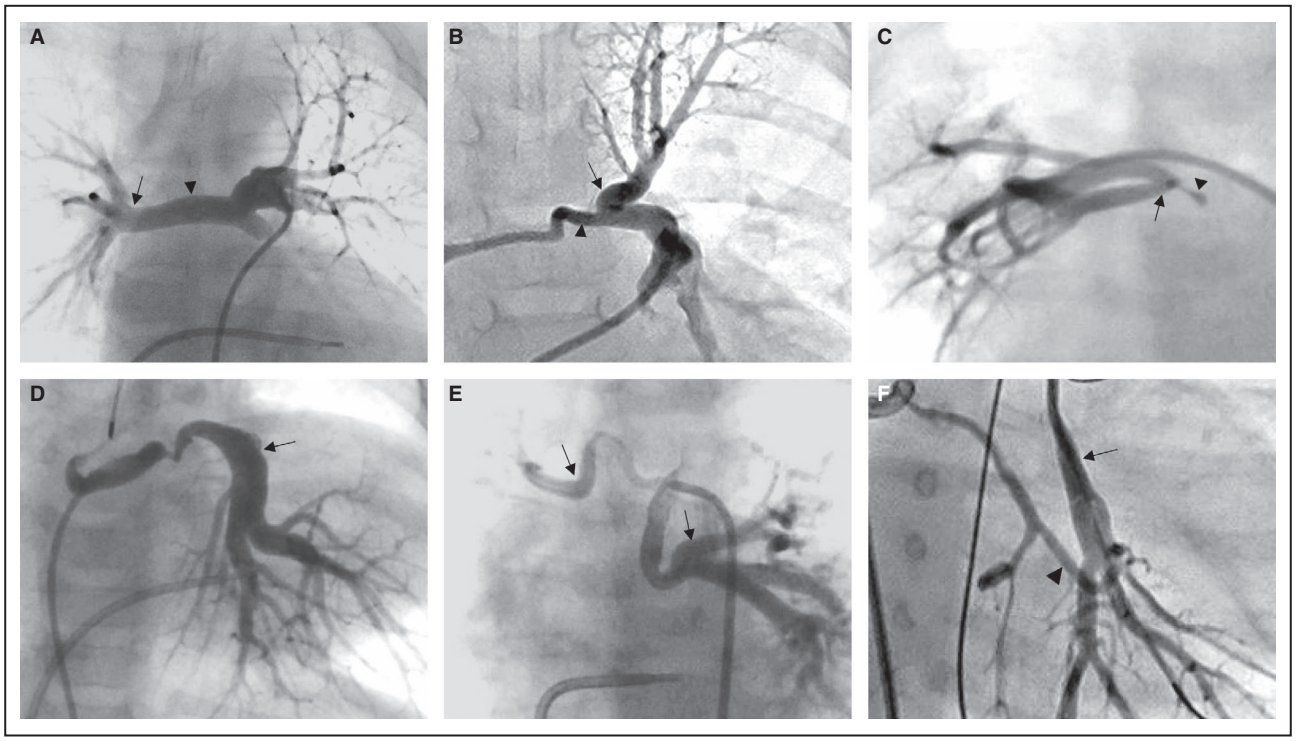

Figure 2. Examples of major aortopulmonary collateral arteries (MAPCA) and central pulmonary arteries (PAs) and location of measurements in 6 different patients.
A, Dual-supply MAPCA connecting at the left hilum and supplying large incompletely arborizing central PAs with intrapericardial (arrowhead) and intrapulmonary (arrow) portions similar in size. **B** and **C**, Dual-supply MAPCAs feeding an incompletely arborizing intrapulmonary PA (arrow) with relatively hypoplastic intrapericardial PAs (arrowhead). **D** and **E**, Single-supply MAPCA with 2 branches, with arrows at the sites of measurement, past all stenoses at the site of anticipated unifocalization. **F**, Dual-supply MAPCA with a small connection to the central PA (arrowhead), which will require unifocalization and be included in the MAPCA index (measured at black arrow).

to a small dual-supply connection to the PAs, it was measured separately and included in the MAPCA index (Figure 2F). The modified Nakata and MAPCA indices were summed to give a total neo-pulmonary artery index (TNPAI), similar to prior work.[13] Patients in whom all measurements could not be made confidently were excluded because of inadequate angiography.

Surgical Management

Our management approach for TOF/MAPCAs has been detailed previously.[1,3] Complete repair refers to unifocalization, ventricular septal defect closure, and placement of a right ventricle (RV) to PA conduit, which are usually performed during the same operation (single-stage repair), and less often in stages. Unifocalization to a central shunt is performed if an intraoperative flow study shows that RV pressure would be too high with ventricular septal defect closure.[13] For patients with hypoplastic normally arborizing central PAs and all dual-supply MAPCAs, an aortopulmonary window is performed early in life as the first surgery.[1,14] Further details about our surgical approach are in Data S1.

Surgical Outcomes

The first surgery was classified as single-stage complete repair, aortopulmonary window, or other palliation (unilateral or bilateral unifocalization to a central shunt, or unilateral PA banding). For patients who did not undergo single-stage complete repair, each subsequent surgery was reviewed, and classified as complete repair (multi-stage) or ongoing palliation (unrepaired). Follow-up was conducted by a combination of medical record review and contact with the primary physician for all patients who did not undergo complete repair at our institution, and patients' current status classified as "unrepaired" or "death without repair". The ratio of right ventricle to aortic pressure (RV:Ao) at time of complete repair was taken in the operating room via intracardiac lines following chest closure, which is routinely recorded in the operative and intensive care unit records.

Patient Grouping and Analysis

One aim of this study was to determine whether an anatomically-based classification system could be derived for patients with MAPCAs. To provide the most detailed analysis possible, we classified patients with

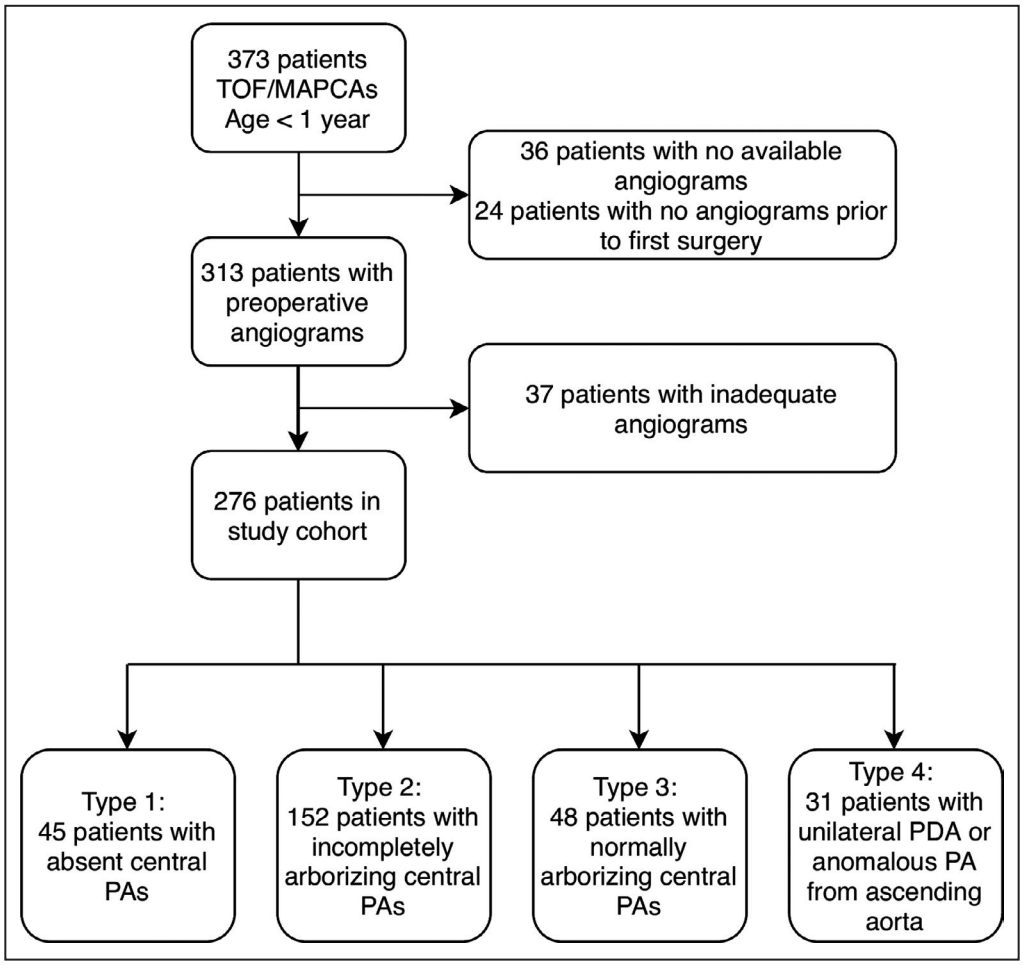

Figure 3. Study flowchart.
Diagram of the exclusion and inclusion criteria and breakdown of included patients by pulmonary artery arborization pattern. PAs indicates pulmonary arteries; PDA, ductus arteriosus; and TOF/MAPCAs, tetralogy of Fallot with major aortopulmonary collateral arteries.

a scheme similar to that proposed by Soquet et al,[15] using features described above plus the number of segments supplied by each MAPCA. Every MAPCA was named according to origin and nature of supply, and patients were organized based on these characteristics, as described in Data S1.

In addition, for the purposes of analysis, patients were grouped according to several criteria: (1) the number of bronchopulmonary segments fed by single-supply MAPCAs (0–3, 4–8, 9–13, and 14–18 segments), (2) the ratio of MAPCA index to TNPAI (0–0.25, 0.25–0.5, 0.5–0.75, and 0.75–1), and (3) the TNPAI (<100, 100–150, 150–200, and >200 mm^2/m^2). Also, based on our management protocol, each patient was assigned to 1 of 4 groups according to central PA arborization and MAPCA supply, similar to the system proposed by Barbero-Marcial[16]:

Type 1: Absent intrapericardial PAs (all single-supply MAPCAs).

Type 2: Incompletely arborizing central PAs (combination of single, dual, and mixed-supply MAPCAs).

Type 3: Normally arborizing central PAs (all dual-supply MAPCAs).

Type 4: Unilateral PDA or anomalous PA arising from the ascending aorta, with MAPCAs to the contralateral PA (with or without an intrapericardial PA segment).

Statistical Analysis

Data were presented as number (%) or median (25th, 75th percentiles). Comparison of categorical variables between groups was performed using Fisher exact test. For numerical variables, Wilcoxon rank sum test or the Kruskal–Wallis test was used. All analyses were performed with R version 3.6.1 and SPSS version 25.0.

RESULTS

Study Cohort

A total of 373 patients <1 year of age with TOF/MAPCAs underwent surgery at our center during the study period. As summarized in Figure 3, 97 of these patients were excluded and the remaining 276 comprised the study cohort. Forty (14%) of the angiograms were performed at outside institutions.

Characteristics of MAPCAs

In these 276 patients, 1068 MAPCAs were identified: 564 (53%) single-supply, 87 (8%) isolated-supply to central PAs, 386 (36%) dual-supply to central PAs, and 31 (3%) mixed-supply. Details are summarized in Table 1. MAPCAs arising from the abdominal aorta were almost always dual-supply (23 of 24), while all 15 MAPCAs from the coronary arteries were dual-supply, and in 6 cases (40%) were the only supply to the central PAs. Nearly all coronary MAPCAs (14 of 15) coursed midline to the intrapericardial PAs. There were 8 MAPCAs with an origin and course suspicious for a PDA that did not supply a normally arborizing unilateral PA and were not associated with the recurrent laryngeal nerve. Other than these 8 MAPCAs and the 14 coronary MAPCAs that coursed to the intrapericardial PAs, all MAPCAs connected at the hilum or more distally in the PA tree. Twenty-six patients had a PDA and 5 had an anomalous PA from the ascending aorta providing full and sole supply to a normally arborizing left (n=29) or right (n=2, 1 PDA, 1 anomalous PA) branch PA.

Patient Details and Anatomy

Demographic, clinical, anatomic, and surgical details of the overall cohort and the 4 anatomic groups are summarized in Table 2.

Anatomy

Patients had 1 to 10 MAPCAs (median 4), with descending thoracic aortic MAPCAs in 99% of patients. The next most common site of origin was the SCA (38%; unilateral in most cases), while MAPCAs from other sites were observed in 5% to 7% of patients each. A right aortic arch was present in 129 (47%) patients and 44 (16%) had an anomalous SCA. Patients with a chromosome 22q11 deletion (n=110, 41%) were more likely to have a right arch, anomalous SCA, and MAPCAs from an SCA, and less likely to have coronary MAPCAs. There were no other differences in MAPCA origins according to 22q11 status or arch sidedness or branching (Table 3 and Table S2). There were several associations between arch sidedness, branching, and SCA origin of MAPCAs; for example, MAPCAs tended to arise from the SCA contralateral to the arch, particularly when anomalous (Table S3). Overall, 31% of SCAs (73 of 232) originating normally from the innominate artery (contralateral to the arch), 12% (33 of 276) of SCAs ipsilateral to the arch, and 41% (18 of 44) of aberrant SCAs had a MAPCA (P<0.001). Coronary anomalies were found in 21% of patients (Table 4).

Intrapericardial PAs were present in 217 (79%) patients. The most common PA pattern was incompletely arborizing central PAs (Type 2; n=152 [55%]), followed

Table 1. Features of MAPCAs Overall and by Type for the Entire Cohort

	MAPCA Type				
	Total MAPCAs (n=1068)	Single-Supply (n=564, 53%)	Isolated Supply to Central PA (n=87, 8%)	Dual-Supply to Central PA (n=386, 36%)	Mixed-Supply (n=31, 3%)
Origin					
Descending thoracic aorta	868 (81%)	487 (86%)	75 (87%)	278 (72%)	28 (90%)
Right subclavian artery	74 (7%)	31 (5%)	3 (3%)	40 (10%)	0 (0%)
Left subclavian artery	71 (7%)	35 (6%)	2 (2%)	31 (8%)	3 (10%)
Coronary artery	15 (1%)	0 (0%)	6 (7%)	9 (2%)	0 (0%)
Transverse aortic arch	16 (1%)	10 (2%)	1 (1%)	5 (1%)	0 (0%)
Abdominal aorta	24 (2%)	1 (<1%)	0 (0%)	23 (6%)	0 (0%)
Course					
Rightward	560 (52%)	309 (55%)	46 (53%)	198 (51%)	7 (23%)
Leftward	384 (36%)	204 (36%)	23 (26%)	151 (39%)	6 (19%)
Bilateral	102 (10%)	51 (9%)	7 (8%)	26 (7%)	18 (58%)
Midline	22 (2%)	0 (0%)	11 (14%)	11 (3%)	0 (0%)
Bronchopulmonary segments supplied	7 (3, 16)	3 (1, 5)	7 (8, 11)	18 (14, 18)	15 (14, 17)

Data presented as n (%) or median (Q1, Q3). MAPCA indicates major aortopulmonary collateral artery; and PA, pulmonary artery.

Table 2. Demographic and Anatomic Features of Patients Overall and by Type of PA Arborization

	Total (n=276)	Type 1: Absent Central PA (n=45)	Type 2: Incompletely Arborizing PA (n=152)	Type 3: Normally Arborizing PA (n=48)	Type 4: PDA or Anomalous PA (n=31)	*P* Value
Demographic features						
Female sex	141 (51%)	22 (49%)	72 (47%)	27 (56%)	20 (65%)	0.30
Age, mo	3.7 (1.0, 6.0)	4.7 (2.5, 6.4)	4.6 (1.7, 6.2)	1.6 (0.1, 4.1)	1.3 (0.2, 4.4)	<0.001
Weight, kg	5.2 (3.7, 6.5)	5.6 (4.3, 6.6)	5.3 (4.0, 6.5)	4.2 (3.5, 6.2)	4.8 (3.6, 5.7)	0.13
Genetic features						
Chromosome 22q11 deletion (n=271)	110 (41%)	25 (56%)	59 (40%)	18 (38%)	8 (27%)	0.085
Alagille syndrome	7 (3%)	1 (2%)	5 (3%)	1 (2%)	0 (0%)	0.94
Anatomic/physiologic features						
Intrapericardial PAs present	217 (79%)	0 (0%)	152 (100%)	48 (100%)	17 (55%)	<0.001
Right aortic arch	129 (47%)	20 (44%)	72 (47%)	25 (52%)	12 (39%)	0.69
Abnormal arch branching	44 (16%)	10 (22%)	24 (16%)	7 (15%)	3 (10%)	0.55
Pulmonary valve stenosis	33 (12%)	0 (0%)	6 (4%)	23 (48%)	4 (13%)	<0.001
Estimated Qp:Qs (n=230)	1.4 (1.0, 2.1)	1.7 (1.0, 2.3)	1.4 (0.9, 2.1)	1.1 (0.9, 1.7)	1.6 (1.3, 3.4)	0.041
No. of MAPCAs	4 (3, 5)	4 (3, 4)	4 (3, 5)	4 (3, 5)	3 (2, 3.5)	<0.001
MAPCA origins						
Thoracic aortic MAPCAs	274 (99%)	45 (100%)	151 (99%)	47 (98%)	31 (100%)	0.70
Thoracic aortic MAPCAs only	153 (55%)	32 (71%)	87 (57%)	17 (35%)	17 (55%)	0.006
Subclavian MAPCAs	105 (38%)	10 (22%)	57 (38%)	28 (58%)	10 (32%)	0.004
Both RSCA and LSCA MAPCAs	26 (9%)	1 (2%)	6 (4%)	19 (40%)	0 (0%)	<0.001
Abdominal aortic MAPCAs	20 (7%)	0 (0%)	2 (1%)	15 (31%)	3 (10%)	<0.001
Coronary MAPCAs	15 (5%)	0 (0%)	5 (3%)	4 (8%)	6 (19%)	0.002
Transverse aortic MAPCAs	15 (5%)	3 (7%)	9 (6%)	2 (4%)	1 (3%)	0.93
PA and MAPCA measurements						
Intrapericardial PA diameter, mm	2.1 (0.8, 3.2)	0 (0, 0)	2.6 (1.8, 3.9)	2.6 (2.1, 3.2)	0.6 (0, 1.4)	<0.001
Intrapericardial PA index, mm^2/m^2	29 (4, 64)	0 (0, 0)	40 (18, 89)	44 (29, 70)	4 (0, 22)	<0.001
Modified nakata, mm^2/m^2	56 (16, 97)	0 (0, 0)	60 (27, 105)	63 (43, 82)	118 (72, 162)	<0.001
MAPCA index, mm^2/m^2	71 (33, 129)	154 (119, 207)	80 (49, 122)	0 (0, 39)	35 (20, 63)	<0.001
TNPAI, mm^2/m^2	148 (99, 195)	154 (119, 207)	165 (111, 204)	80 (51, 116)	165 (121, 225)	<0.001
First surgery						
Complete repair	182 (66%)	34 (76%)	109 (72%)	20 (42%)	19 (61%)	<0.001
Aortopulmonary window	35 (13%)	0 (0%)	10 (7%)	25 (52%)	0 (0%)	
Other palliation	59 (21%)	11 (24%)	33 (22%)	3 (6%)	12 (39%)	
Current status						
Single-stage complete repair	182 (66%)	34 (76%)	109 (72%)	20 (42%)	19 (61%)	<0.001
Multi-stage complete repair	67 (24%)	7 (16%)	27 (18%)	25 (52%)	8 (26%)	
Unrepaired	12 (4%)	1 (2%)	6 (4%)	3 (6%)	2 (6%)	
Death without repair	15 (5%)	3 (7%)	10 (7%)	0 (0%)	2 (6%)	
Complete repair (ever)	249 (90%)	41 (91%)	136 (89%)	45 (94%)	27 (87%)	0.76
RV:Ao at complete repair	0.33 (0.28, 0.40)	0.31 (0.27, 0.36)	0.33 (0.28, 0.40)	0.31 (0.28, 0.38)	0.34 (0.25, 0.40)	0.40

Data presented as n (%) or median (Q1, Q3). LSCA indicates left subclavian artery; MAPCA, major aortopulmonary collateral artery; PA, pulmonary artery; PDA, ductus arteriosus; Qp:Qs, ratio of pulmonary to systemic blood flow; RV:Ao, ratio of right ventricle to aortic pressure; and TNPAI, total neo-pulmonary artery index.

by normally arborizing PAs (Type 3; n=48 [17%]), and absent central PAs (Type 1; n=45 [16%]), with a PDA or anomalous PA from the ascending aorta and contralateral MAPCAs (Type 4) the least common pattern (n=31, 11%). Among patients with intrapericardial PAs, a median of 12 (9, 17) pulmonary segments were associated with the central PAs. There was remarkable variability in the number, origin, and segmental supply of MAPCAs, and in PA arborization, but some associations were apparent. Patients that were Type 1 were

Table 3. Features of the Pulmonary Circulation According to Chromosome 22q11 Status

	Total (n=271)	Chromosome 22q11 Deletion		*P* Value
		No (n=161)	Yes (n=110)	
Thoracic aorta MAPCAs	269 (99%)	160 (99%)	109 (99%)	>0.99
Thoracic aorta MAPCAs only	151 (56%)	93 (58%)	58 (53%)	0.46
Subclavian MAPCAs	103 (38%)	53 (33%)	50 (45%)	0.042
Abdominal MAPCAs	20 (7%)	12 (7%)	8 (7%)	>0.99
Coronary MAPCAs	14 (5%)	12 (7%)	2 (2%)	0.050
Transverse arch MAPCAs	15 (6%)	10 (6%)	5 (5%)	0.60
RSCA and LSCA MAPCAs	25 (9%)	15 (9%)	10 (9%)	>0.99
Intrapericardial PAs	213 (79%)	132 (82%)	81 (74%)	0.13
Right aortic arch	127 (47%)	59 (37%)	68 (62%)	<0.001
Abnormal arch branching	44 (16%)	9 (6%)	35 (32%)	<0.001
Pulmonary stenosis	33 (12%)	23 (14%)	10 (9%)	0.26
Modified Nakata, mm^2/m^2	56 (16, 99)	60 (22, 111)	44 (13, 90)	0.089
MAPCA index, mm^2/m^2	72 (32, 129)	65 (29, 119)	86 (39, 146)	0.040
TNPAI, mm^2/m^2	149 (100, 197)	150 (94, 193)	149 (108, 200)	0.66
Complete repair	245 (90%)	143 (89%)	102 (93%)	0.30
RV:Ao at complete repair	0.33 (0.28, 0.40)	0.31 (0.26, 0.37)	0.35 (0.30, 0.41)	<0.001

Only includes patients with known presence or absence of a chromosome 22q11 deletion. Data presented as n (%) or median (Q1, Q3). LSCA indicates left subclavian artery; MAPCA, major aortopulmonary collateral artery; PA, pulmonary artery; RSCA, right subclavian artery; RV:Ao, ratio of right ventricle to aortic pressure; and TNPAI, total neo-pulmonary artery index.

more likely to have exclusively descending thoracic aorta MAPCAs than other types (*P*=0.006), while Type 3 were more likely to have abdominal aorta (*P*<0.001) and bilateral SCA MAPCAs (*P*=0.004).

Pulmonary valve stenosis occurred in about half (n=23, 48%) of patients with Type 3, and rarely in Type 4 (n=4, 13%) or Type 2 (n=6, 4%). In 3 of the 4 patients with Type 4 with pulmonary stenosis, the nearly atretic RV outflow tract supplied a hypoplastic normally arborizing single PA. Thus, of the 33 instances of pulmonary stenosis, 26 (79%) were associated with uni- or bilateral hypoplastic normally arborizing PAs. In the patients with Type 2 with pulmonary stenosis, a majority of bronchopulmonary segments (from 12 to 17) connected to the central PAs.

A MAPCA naming system based on origin, supply type, and number of bronchopulmonary segments supplied is detailed in Data S1. When the names of each MAPCA in a given patient were strung together, there were 222 unique codes among the 276 patients, of which 187 (84%) occurred only once. This scheme did not account for additional factors such as the specific segments supplied, the number or severity of PA stenoses, or the location and size of connections of dual-supply MAPCAs to the PAs. Given this heterogeneity, additional attempts to group patients using this methodology were not pursued.

Table 4. Coronary Artery Anomalies

Coronary Artery Pattern and Anomalies (34 Unknown, n=242)	
Normal pattern and supply	192 (79%)
LAD from the right	11 (4.5%)
Dual LAD	4 (1.7%)
Anomalous right from left main	7 (2.9%)
Anomalous left main from right	8 (3.3%)
Coronary artery fistula	5 (2.1%)
MAPCA	15 (6.2%)

LAD indicates left anterior descending; and MAPCA, major aortopulmonary collateral artery.

MAPCA and PA indices

As documented in Table 2 and Figure 4, the TNPAI was significantly lower in patients with Type 3 (*P*<0.001). Within patients with Type 3, those with pulmonary atresia and pulmonary stenosis had similar TNPAI (86.0 [62.3, 125.8] versus 70.2 [46.2, 98.3], *P*=0.066) and intrapericardial PA diameter (2.6 [2.4, 3.2] versus 2.5 [2.1, 3.3]; *P*=0.71).

Patients with and without a chromosome 22q11 deletion had similar TNPAI, but on average those with a deletion had more cross-sectional area contributed by single-supply MAPCAs (Table 3). Patients with Alagille syndrome had lower TNPAI than those without (89.3 [70.5, 131.0] versus 149.1 [100.4, 197.5] mm^2/m^2; *P*=0.043).

Outcomes

Selected surgical outcomes are summarized in Tables 4 through 7. No patients who underwent complete repair

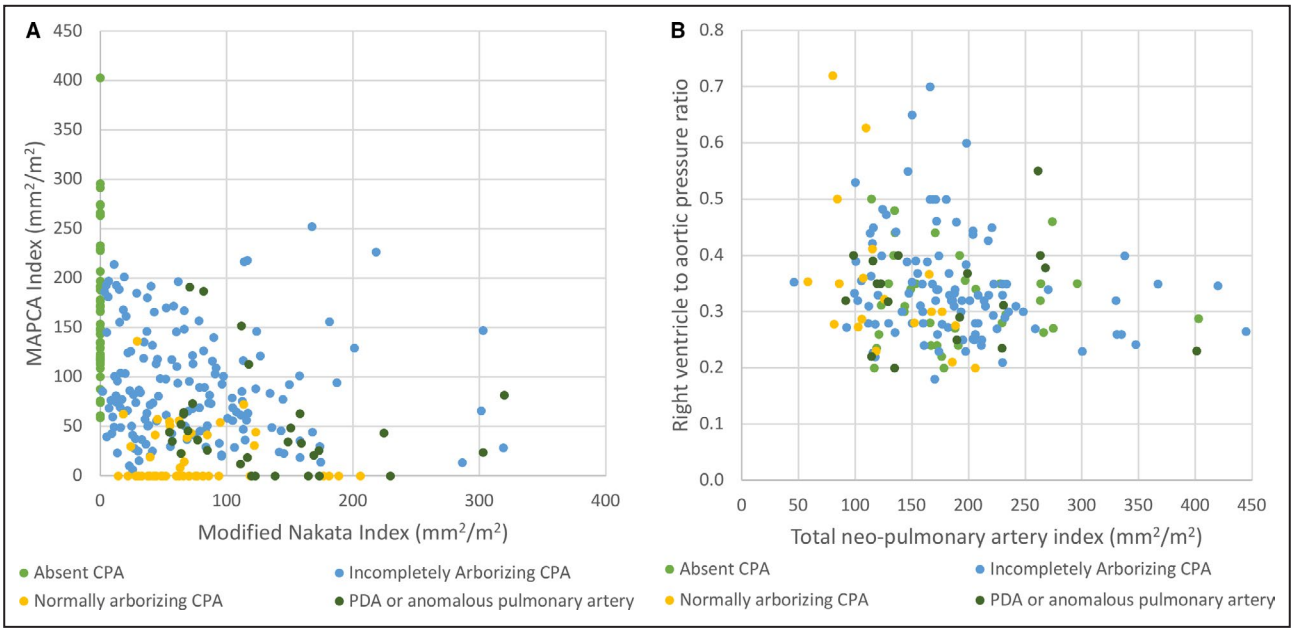

Figure 4. Relationship of pulmonary artery indices and postoperative right ventricle pressure according to pulmonary artery arborization pattern.
Scatterplots showing relationships of (**A**) major aortopulmonary collateral artery index, the modified Nakata index, and patient central pulmonary artery (CPA) arborization pattern (in all patients), and (**B**) postoperative right ventricle to aortic pressure ratio, the total neopulmonary artery index, and the central pulmonary artery arborization pattern (in patients who underwent complete repair). PDA indicates ductus arteriosus; and MAPCAs, major aortopulmonary collateral arteries.

had the ventricular septal defect opened or the RV-PA connection taken down. Patients with Type 3 and Type 4 were more likely to require a staged approach ($P<0.001$), but ultimately there was no significant difference in the proportion of patients reaching complete repair or in the post-repair RV:Ao between anatomic groups or according to the number of bronchopulmonary segments supplied by single-supply MAPCAs (Table 3 and Figure 4).

Patients with a larger TNPAI were more likely to undergo single-stage complete repair (Table 6 and Figure 5). A TNPAI <100 mm²/m² was associated with remaining unrepaired or experiencing death before complete repair, though 55 (77%) of these patients did achieve complete repair with an RV:Ao of 0.35 (0.28, 0.40). Among patients who achieved complete repair, there was no association between TNPAI and the postoperative RV:Ao. A summary figure with selected

Table 5. Surgical Outcomes Overall and According to the Number of Single-Supply Pulmonary Segments

Outcome	Total (n=276)	No. of Single-Supply Pulmonary Segments				*P* Value
		0–3 (n=98)	4–8 (n=64)	9–13 (n=64)	14–18 (n=50)	
First surgery						
Complete repair	182 (66%)	53 (54%)	51 (80%)	41 (64%)	37 (74%)	<0.001
Aortopulmonary window	35 (13%)	30 (31%)	3 (5%)	2 (3%)	0 (0%)	
Other palliation	59 (21%)	15 (15%)	10 (16%)	21 (33%)	13 (26%)	
Current status						
Single-stage complete repair	182 (66%)	53 (54%)	51 (80%)	41 (64%)	37 (74%)	0.020
Multi-stage complete repair	67 (24%)	36 (37%)	8 (12%)	14 (22%)	9 (18%)	
Unrepaired	12 (4%)	5 (5%)	1 (2%)	5 (8%)	1 (2%)	
Death without repair	15 (5%)	4 (4%)	4 (6%)	4 (6%)	3 (6%)	
Complete repair (ever)	249 (90%)	89 (91%)	59 (92%)	55 (86%)	46 (92%)	0.66
RV:Ao at complete repair	0.33 (0.28, 0.40)	0.32 (0.28, 0.39)	0.32 (0.28, 0.38)	0.35 (0.30, 0.43)	0.33 (0.27, 0.38)	0.31

Data presented as n (%) or median (Q1, Q3). RV:Ao indicates ratio of right ventricle to aortic pressure.

Table 6. Surgical Outcomes Overall and According to TNPAI Grouping

Outcome	Total (n=276)	TNPAI (mm^2/m^2)				*P* Value
		0–100 (n=71)	100–150 (n=70)	150–200 (n=72)	>200 (n=63)	
First surgery						
Complete repair	182 (66%)	11 (15%)	50 (71%)	63 (88%)	58 (92%)	<0.001
Aortopulmonary window	35 (13%)	31 (44%)	3 (4%)	1 (1%)	0 (0%)	
Other palliation	59 (21%)	29 (41%)	17 (24%)	8 (11%)	5 (8%)	
Current status						
Single-stage complete repair	182 (66%)	11 (15%)	50 (71%)	63 (88%)	58 (92%)	<0.001
Multi-stage complete repair	67 (24%)	44 (62%)	14 (20%)	5 (7%)	4 (6%)	
Unrepaired	12 (4%)	8 (11%)	1 (1%)	2 (3%)	1 (2%)	
Death without repair	15 (5%)	8 (11%)	5 (7%)	2 (3%)	0 (0%)	
Complete repair (ever)	249 (90%)	55 (77%)	64 (91%)	68 (94%)	62 (98%)	<0.001
RV:Ao at complete repair	0.33 (0.28, 0.40)	0.35 (0.28, 0.40)	0.35 (0.29, 0.42)	0.33 (0.28, 0.38)	0.31 (0.26, 0.35)	0.053

Data presented as n (%) or median (Q1, Q3). RV:Ao indicates ratio of right ventricle to aortic pressure; and TNPAI, total neo-pulmonary artery index.

central PA angiograms and surgical outcomes is shown in Figure S1.

DISCUSSION

It is challenging to assess and evaluate all of the features of the pulmonary circulation in TOF/MAPCAs in an integrated but straightforward and coherent fashion. This difficulty has potential implications for both treatment and investigation of outcomes and risk factors. In this report, which is the most comprehensive evaluation of pulmonary vascular anatomy in patients with TOF/MAPCAs, we described the highly variable anatomy of >1000 MAPCAs and central PA configurations in 276 infants, providing novel insight into the distribution and constellation of anatomic features in this population. We also attempted to characterize the variations in the pulmonary circulation, but the data revealed that the extensive variability of MAPCA anatomy and supply confounds useful systematic classification. As vexing as that may be, this study also confirmed our empirical impression that if the surgical principles of using all available raw material (all MAPCAs and the central PAs) are adhered to, a good early surgical outcome can be achieved for essentially any anatomic variation.

Anatomy

In this experience, there were minor associations between MAPCA number, origin, supply, arch anatomy, and genetic status, adding to prior smaller reports.[17–20] The presence of a unilateral PDA or anomalous PA from the ascending aorta, for example, should prompt careful evaluation for coronary MAPCAs. Abdominal aorta MAPCAs and MAPCAs from both SCAs were typically, although not always, associated with a normally arborizing PA tree, and awareness of this association may

Table 7. Surgical Outcomes Overall and According to the Ratio of the MAPCA Index to the TNPAI

Outcome	Total (n=276)	MAPCA Index/TNPAI				*P* Value
		0–0.25 (n=65)	0.25–0.5 (n=69)	0.5–0.75 (n=54)	0.75–1 (n=88)	
First surgery						
Complete repair	182 (66%)	30 (46%)	53 (77%)	39 (72%)	60 (68%)	<0.001
Aortopulmonary window	35 (13%)	23 (35%)	5 (7%)	4 (7%)	3 (3%)	
Other palliation	59 (21%)	12 (18%)	11 (16%)	11 (20%)	25 (28%)	
Current status						
Single-stage complete repair	182 (66%)	30 (46%)	53 (77%)	39 (72%)	60 (68%)	0.003
Multi-stage complete repair	67 (24%)	29 (45%)	12 (17%)	8 (15%)	18 (20%)	
Unrepaired	12 (4%)	3 (5%)	3 (4%)	3 (6%)	3 (3%)	
Death without repair	15 (5%)	3 (5%)	1 (1%)	4 (7%)	7 (8%)	
Complete repair (ever)	249 (90%)	59 (91%)	65 (94%)	47 (87%)	78 (89%)	0.52
RV:Ao at complete repair	0.33 (0.28, 0.40)	0.30 (0.26, 0.38)	0.33 (0.30, 0.41)	0.33 (0.28, 0.39)	0.34 (0.28, 0.40)	0.55

Data presented as n (%) or median (Q1, Q3). MAPCA indicates ratio of the major aortopulmonary collateral arteries; RV:Ao, ratio of right ventricle to aortic pressure; and TNPAI, total neopulmonary artery index.

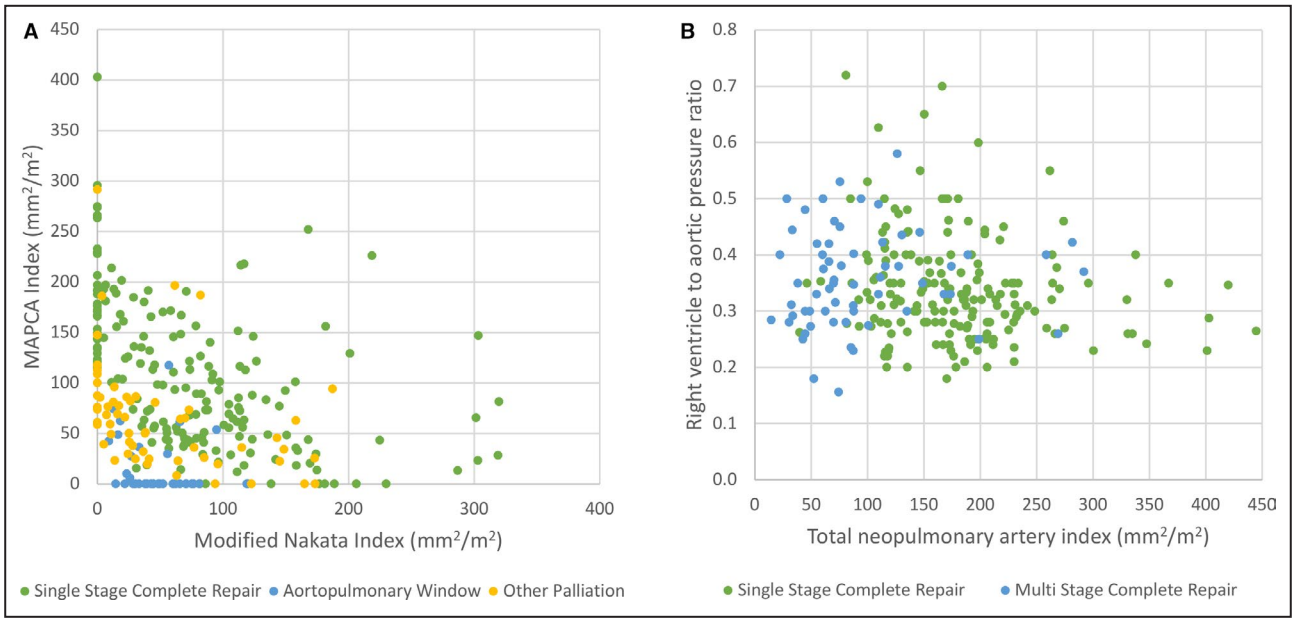

Figure 5. Relationship of pulmonary artery indices and postoperative right ventricle pressure according to surgical approach.
Scatterplots showing relationships of (**A**) major aortopulmonary artery index, modified Nakata index, and the first surgical procedure performed (in all patients), and (**B**) postoperative right ventricle to aortic pressure ratio, the total neopulmonary artery index, and single vs. multi-stage complete repair (in patients who underwent complete repair). In (**A**) patients with the lowest total neopulmonary artery index are closest to the left-lower corner and tended to be managed with a palliative procedure. However, of those who achieved complete repair (**B**), the right ventricle to aortic pressure was similar regardless of initial total neopulmonary artery index. MAPCA indicates major aortopulmonary collateral arteries.

be helpful during the evaluation of these patients. While understanding the associations found in this study are important for case planning, they do not appear to provide extensive insight into other anatomic features or outcomes.

Patients with normal or near-normally arborizing PAs tended to have more MAPCAs but a lower TNPAI compared with those with absent intrapericardial PAs. One possible explanation for this seemingly paradoxical phenomenon is that competitive flow from multiple sources could adversely affect the development of distal vasculature. This observation also suggests that the MAPCAs in this subgroup may have been acquired in fetal life, rather than having developed from early embryologic foregut vessels. The normal arborization of the central PA system, and the occasional patency of the pulmonary valve, also supports this hypothesis of a fetal process occurring after embryogenesis is completed.

Contrary to prior reports,[21,22] there were no significant differences in PA size or anatomy between patients with and without a chromosome 22q11 deletion. The few patients with Alagille in this cohort had markedly less PA/MAPCA cross-sectional area, which we believe is a driver of relatively poor outcome.[1,3] There was a high prevalence of coronary artery anomalies, including MAPCAs and coronaries crossing the RV outflow tract, and therefore preoperative coronary angiography is required.

Outcomes

Patients with large central PAs, large MAPCAs, or both (ie, a large TNPAI) had the highest likelihood of single-stage complete repair and tended to have lower early RV:Ao. Even among patients with the lowest TNPAI (<100 mm²/m²), a majority (>75%) eventually underwent repair with acceptable RV pressure. Few patients with a high TNPAI had a high post-repair RV pressure or did not undergo single-stage repair. Though estimating the TNPAI may help frame expectations about the likelihood of 1-stage repair, we do not use quantitative preoperative estimates of post-reconstruction PA size in surgical decision-making.

Despite the anatomic variability between patients with the different PA arborization patterns (Types 1–4), outcomes did not differ. Nevertheless, we believe that grouping patients based on PA arborization pattern is useful, since it has bearing on the timing and type of surgery.[1,3,23] Patients with Type 3, for example, undergo an elective aortopulmonary window early in life,[14,23] and patients with Type 4 often undergo neonatal intervention to control pulmonary blood flow to the lung without MAPCAs,[1] which helps account for the significant difference in first surgery between patients groups.

There is ongoing debate about the relative effectiveness of unifocalization[3,24,25] versus PA rehabilitative

approaches[10] (or a combination thereof[2,4,26,27]) for patients with incompletely arborizing PAs. The crux of management decisions at certain centers relies on the perceived dominance of central PAs or single-supply MAPCAs in an individual patient. We did not find MAPCA or central PA dominance, based on the number of lung segments supplied by single-supply MAPCAs or by the MAPCA index:TNPAI ratio, to be associated with differences in the rate of complete repair or in the immediate RV:Ao. Though there remains a sentiment that central PAs are a superior platform for repair,[15] the findings of this study suggest that PA segments supplied by single-supply MAPCAs are just as conducive to an overall good immediate repair as PA segments associated with an arborizing central PA. However, absent central PAs were associated with a higher incidence of surgical reintervention for elevated PA pressures,[28] and it is possible that certain PA arborization patterns will fare more poorly over time. Analysis of longer-term outcomes according to patient anatomic groupings described in this article is a subject of ongoing study. Overall, longer-term outcomes are generally favorable.[3]

It is our impression that once a MAPCA reaches the lung parenchyma, lung segments supplied by MAPCAs are indistinguishable from segments arborizing from central PAs, in terms of both quality and distribution. The use of a particular segment in the PA reconstruction does not appear to be related directly to the native course that blood takes to supply that segment. It is necessary that the physiology and anatomy of each lung segment is understood before surgery, such that the surgeon can plan the reconstruction and ensure unobstructed supply to all segments. Complex anatomies are more time intensive and technically challenging but following our approach the RV:Ao generally did not differ.

Although we and others have found worse long-term survival in patients with a chromosome 22q11 deletion than those without,[3,4,29,30] in this study there was no difference in the proportion of patients who achieved complete repair and only marginal differences in the post-repair RV:Ao. These immediate outcome data coupled with the anatomic findings in this study suggest that differences in long-term mortality in patients with a chromosome 22q11 deletion may be unrelated to PA size or anatomy.

Classification

Current classification systems place TOF/MAPCAs as a subset of TOF or ventricular septal defect with pulmonary atresia and/or by presence or absence of intrapericardial PAs.[31] Others have proposed different groupings,[4,15,16,32] but these have not been widely adopted. A system similar to the primary grouping in this study was proposed in 1990 by Barbero-Marcial et al.[16]

Our data suggests that in TOF/MAPCAs essentially every arborization pattern of the PAs, every variation of intrapericardial versus intrapulmonary PA size, and every combination of MAPCA origin and distribution exist on a spectrum, and that none of these variations are strongly associated with early surgical outcomes when using our management strategy and surgical techniques. Although we hoped this study would allow us to discern useful anatomic patterns for classifying patients, we conclude that attempts at a nomenclature system for TOF/MAPCAs will be either too simple or too complicated to be meaningfully tied to clinical outcomes. We continue to group patients (Type 1–4) primarily to facilitate communication about basic PA anatomy and the expected surgical management. Understanding all details, including MAPCA and central PA size, connections, stenoses, and other relationships in each individual case is necessary for the surgeon to achieve a good outcome.

Limitations

Limitations of this study include the single institution retrospective design. The majority of patients were referred from outside our local catchment area, and it is possible that selection bias may limit the generalizability of our findings to the overall population of patients with TOF/MAPCAs. There are significant limitations to using PA indices in patients with TOF/MAPCAs.[4,13] In a minority of cases, there was a degree of subjectivity between what was considered in the modified Nakata Index versus the MAPCA index, but all important cross-sectional PA area was included in the TNPAI, and the fact that these measurements had no influence on surgical decisions increases their power as a retrospective tool. The high repair rate and generally low RV:Ao in this study limits the ability to detect outcome differences between anatomic subtypes, which might be revealed in a larger cohort. There are other anatomic features, particularly the quality of the distal vasculature, that we could not systemically characterize. Therefore, though there are no statistically differences in early outcomes in the majority of analyses, it is possible that other anatomic features may be related to early outcomes in a more complex manner than this analysis could detect. Furthermore, this study was focused on characterization of pulmonary vascular supply, and was limited to early outcomes. Assessment of longer-term outcomes according to detailed PA anatomy is the subject of ongoing study.

CONCLUSIONS

In TOF/MAPCAs, the distribution of MAPCAs is highly variable and essentially unique for each patient. Though each pulmonary segment can be supplied

by a MAPCA, central PA, or both, in our analysis the type of supply was not associated with early surgical outcome, and all anatomic combinations were conducive to a good repair. Of the variables we studied, total cross-sectional area of central PA and MAPCA material (TNPAI) was an important driver of outcome, with those having a paucity of total material being the most challenging patients to manage. We highlighted a number of novel associations between anatomic features as well as genetic associations, but ultimately the extreme variability of the pulmonary circulation makes a granular classification scheme unrealistic. Nevertheless, grouping patients according to PA arborization pattern has clinical utility with regard to the preoperative evaluation and surgical management.

ARTICLE INFORMATION

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None.

Supplementary Material

Data S1
Tables S1–S3
Figure S1

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Supplemental Material

Data S1.

Supplemental Methods

Surgical Approach:

Our programmatic management algorithm for TOF/MAPCAs aims for early complete unifocalization and intracardiac repair incorporating all lung segments, with augmentation of PA branches (whether arborizing from the central PAs or supplied by MAPCAs) down to the segmental level. The majority of patients (i.e. those with incompletely arborizing or absent central PAs) are scheduled for elective surgery at 4-6 months of age. Unifocalization is individualized based on the anatomy of the PAs and the MAPCAs, and the angiograms are displayed in the operating room as a roadmap. Distal branches are probed to assess diameter, orientation, and the presence of stenoses, and MAPCAs are dissected out to the segmental level to maximize vessel length. To minimize the likelihood of recurrent stenosis, native tissue is utilized for all anastomoses and PA reconstructions when possible. Patch augmentations are performed with PA homograft, and circumferential patches are avoided in order to preserve the growth of native tissue. Anastomoses between MAPCAs and central PAs are performed with extended side-to-side connections, typically to the posterior aspect of the augmented central PAs. These anastomoses extend into the lung parenchyma where collateral vessels generally are no longer distinguishable from normally arborizing PAs[1].

MAPCA naming system

Methodology:

As described in the manuscript, each MAPCA has an origin (subclavian artery (SCA), transverse arch (TVA), descending thoracic aorta (DTA), abdominal aorta (ABA), or coronary artery (CA)) and supply type (single-supply (SS), isolated supply to central PAs (CSS), dual-supply (DS), or mixed-supply(MS)), and can fully or partially supply 1 to 18 bronchopulmonary segments. Additionally, there are unilateral patent ductus arteriosus (PDA) and anomalous pulmonary arteries arising from the ascending aorta (HT).

Each MAPCA was assigned names based on identifiers of origin, supply type, and segmental supply. There were two names assigned – one based only on MAPCA type and segmental supply, and one based on all three: origin, supply type, and segmental supply. As examples, a single-supply MAPCA arising from the descending thoracic aorta supplying 8 segments was named SS-8 (Type-#Segments) or DTA-SS-8 (Origin-Type-#Segments). A dual-supply MAPCA from the descending thoracic aorta that connects to a normally arborizing PA system was named DS-18 or DTA-DS-18.

Each patient was then coded by stringing together the MAPCA names. For each patient, MAPCAs were listed in order of largest number of segments supplied. For example, a patient with 3 MAPCAs (DTA-SS-5, DTA-SS-7, and DTA-CSS-6) would be named “DTA-SS-7,DTA-CSS-6,DTA-SS-5”. If the number of segments in two MAPCAs were identical, the order was alphabetical.

Results:

A total of 1,068 MAPCAs, 26 PDAs, and 5 HTs were included. By the more basic system (Type-#Segments), there were 57 different MAPCA names, and by Origin-Type-#Segments there were 113 different MAPCA names. By Type-#Segments, out of 276 patients there were 176 different patient codes, 124 (70%) of which occurred only once. By Origin-Type-#Segments, out of 276 patients there were 222 patient codes, 187 (84%) of which occurred only once.

Patient naming by Origin-Type-#Segments is shown below:

# of Patients	Patient Type by MAPCA Origin-Type-#Segments
7	DTA-DS-18,DTA-DS-18
5	DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18
4	ABA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,RSCA-DS-18
4	DTA-DS-18,DTA-DS-18,DTA-DS-18
4	DTA-DS-18,DTA-DS-18,RSCA-DS-18
3	DTA-CSS-13,DTA-SS-3,DTA-SS-2
3	DTA-SS-10,DTA-SS-8
3	DTA-SS-10,PDA-8
3	DTA-SS-8,DTA-SS-7,DTA-SS-3
3	DTA-SS-8,DTA-SS-8,DTA-SS-2
2	DTA-CSS-10,DTA-SS-4,DTA-SS-4
2	DTA-CSS-10,PDA-8
2	DTA-CSS-11,DTA-SS-3,DTA-SS-2,DTA-SS-2
2	DTA-CSS-12,DTA-SS-3,DTA-SS-2,DTA-SS-1
2	DTA-CSS-12,DTA-SS-5,DTA-SS-1
2	DTA-CSS-15,DTA-SS-2,DTA-SS-1
2	DTA-CSS-16,DTA-SS-2
2	DTA-CSS-7,DTA-SS-4,DTA-SS-3,DTA-SS-3,DTA-SS-1
2	DTA-CSS-9,DTA-SS-3,DTA-SS-3,DTA-SS-2,DTA-SS-1
2	DTA-DS-10,DTA-DS-10,DTA-SS-7,DTA-SS-1
2	DTA-DS-12,DTA-DS-12,DTA-DS-12,DTA-SS-4,DTA-SS-2
2	DTA-DS-15,DTA-DS-15,DTA-SS-2,DTA-SS-1
2	DTA-DS-15,DTA-DS-15,DTA-SS-3
2	DTA-DS-16,DTA-DS-16,DTA-DS-16,DTA-SS-1,DTA-SS-1
2	DTA-DS-16,DTA-DS-16,DTA-SS-2
2	DTA-DS-17,DTA-DS-17,DTA-DS-17,DTA-SS-1
2	DTA-DS-17,DTA-DS-17,DTA-SS-1
2	DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,RSCA-DS-18
2	DTA-DS-18,DTA-DS-18,LSCA-DS-18,RSCA-DS-18
2	DTA-MS-17,DTA-SS-1
2	DTA-SS-14,DTA-SS-2,DTA-SS-1,DTA-SS-1
2	DTA-SS-8,DTA-SS-6,DTA-SS-3,DTA-SS-1
2	DTA-SS-9,DTA-SS-8,DTA-SS-1
2	DTA-SS-9,PDA-8,DTA-SS-1
2	PDA-8,DTA-SS-6,DTA-SS-4
1	ABA-DS-10,DTA-DS-10,DTA-DS-10,DTA-DS-10,RSCA-DS-10,PDA-8
1	ABA-DS-10,DTA-DS-10,DTA-DS-10,RSCA-DS-10,PDA-8
1	ABA-DS-10,DTA-DS-10,RSCA-DS-10,TVA-DS-10,HT-8
1	ABA-DS-18,ABA-DS-18,CA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,RSCA-DS-18

1	ABA-DS-18,ABA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,RSCA-DS-18,RSCA-DS-18
1	ABA-DS-18,ABA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,RSCA-DS-18
1	ABA-DS-18,ABA-DS-18,DTA-DS-18,DTA-DS-18,RSCA-DS-18
1	ABA-DS-18,CA-DS-18,LSCA-DS-18,RSCA-DS-18
1	ABA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18
1	ABA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,LSCA-DS-18,RSCA-DS-18
1	ABA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,RSCA-DS-18
1	ABA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,RSCA-DS-18,RSCA-DS-18,TVA-DS-18
1	ABA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18
1	ABA-DS-18,DTA-DS-18,LSCA-DS-18,LSCA-DS-18,LSCA-DS-18,RSCA-DS-18
1	ABA-DS-8,DTA-DS-8,DTA-DS-8,DTA-DS-8,DTA-SS-8,RSCA-DS-8,RSCA-SS-2
1	CA-CSS-8,DTA-SS-5,DTA-SS-2,DTA-SS-2,DTA-SS-1
1	CA-CSS-8,PDA-8,DTA-SS-1,RSCA-SS-1
1	CA-DS-10,DTA-DS-10,DTA-DS-10,RSCA-DS-10,DTA-SS-4,RSCA-SS-4
1	CA-DS-18,DTA-DS-18,DTA-DS-18
1	CA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18
1	CA-DS-9,DTA-DS-9,DTA-SS-6,DTA-SS-3
1	DTA-CSS-10,DTA-SS-3,RSCA-SS-3,DTA-SS-2
1	DTA-CSS-10,DTA-SS-8
1	DTA-CSS-11,DTA-SS-3,DTA-SS-2,DTA-SS-1,DTA-SS-1
1	DTA-CSS-11,DTA-SS-3,RSCA-SS-2,DTA-SS-1,DTA-SS-1
1	DTA-CSS-11,DTA-SS-4,DTA-SS-2,DTA-SS-1
1	DTA-CSS-11,DTA-SS-4,DTA-SS-3
1	DTA-CSS-11,DTA-SS-4,LSCA-SS-2,DTA-SS-1
1	DTA-CSS-11,DTA-SS-5,DTA-SS-2
1	DTA-CSS-11,DTA-SS-7
1	DTA-CSS-11,RSCA-SS-4,DTA-SS-3
1	DTA-CSS-13,TVA-SS-3,DTA-SS-2
1	DTA-CSS-14,DTA-SS-1,DTA-SS-1,DTA-SS-1,RSCA-SS-1
1	DTA-CSS-14,DTA-SS-3,DTA-SS-1
1	DTA-CSS-15,RSCA-SS-2,RSCA-SS-1
1	DTA-CSS-17,DTA-SS-1
1	DTA-CSS-7,DTA-SS-3,LSCA-SS-3,DTA-SS-2,DTA-SS-2,DTA-SS-1
1	DTA-CSS-6,DTA-SS-4,DTA-SS-4,DTA-SS-3,DTA-SS-1
1	DTA-CSS-6,DTA-SS-5,DTA-SS-4,DTA-SS-2,DTA-SS-1
1	DTA-CSS-6,DTA-SS-5,LSCA-SS-3,DTA-SS-2,DTA-SS-2
1	DTA-CSS-7 DTA-SS-5,DTA-SS-4,DTA-SS-1, RSCA-SS-1
1	DTA-CSS-7,DTA-SS-4,DTA-SS-3,DTA-SS-2,RSCA-SS-2
1	DTA-CSS-7,DTA-SS-5,DTA-SS-4,LSCA-SS-2
1	DTA-CSS-7,DTA-SS-5,RSCA-SS-5,ABA-SS-1
1	DTA-CSS-7,DTA-SS-6,DTA-SS-2,DTA-SS-1,DTA-SS-1,DTA-SS-1,LSCA-SS-1
1	DTA-CSS-7,DTA-SS-6,DTA-SS-3,DTA-SS-2
1	DTA-CSS-7,DTA-SS-6,DTA-SS-3,TVA-SS-2
1	DTA-CSS-7,DTA-SS-7,DTA-SS-4
1	DTA-CSS-7,LSCA-SS-6,DTA-SS-2,DTA-SS-2,DTA-SS-1
1	DTA-CSS-7,RSCA-SS-6,DTA-SS-4,DTA-SS-1
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1	DTA-CSS-8,DTA-SS-4,DTA-SS-3,DTA-SS-3
1	DTA-CSS-8,DTA-SS-4,LSCA-SS-4,DTA-SS-2
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1	DTA-CSS-9,DTA-SS-6,DTA-SS-3
1	DTA-CSS-9,DTA-SS-6,RSCA-SS-3
1	DTA-DS-10,DTA-DS-10,DTA-DS-10,DTA-DS-10,PDA-8
1	DTA-DS-10,DTA-DS-10,DTA-DS-10,DTA-SS-4,DTA-SS-2,LSCA-SS-2
1	DTA-DS-10,DTA-DS-10,DTA-DS-10,PDA-8

1	DTA-DS-10,DTA-DS-10,DTA-SS-3,DTA-SS-2,LSCA-SS-2,DTA-SS-1
1	DTA-DS-11,DTA-DS-11,LSCA-SS-4,DTA-SS-3,DTA-SS-1
1	DTA-DS-12,DTA-DS-12,DTA-SS-3,DTA-SS-3
1	DTA-DS-12,DTA-DS-12,DTA-SS-4,DTA-SS-2
1	DTA-DS-13,DTA-DS-13,DTA-DS-13,DTA-SS-5
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1	DTA-DS-13,DTA-DS-13,DTA-SS-4,DTA-SS-1
1	DTA-DS-13,DTA-DS-13,RSCA-SS-4,DTA-SS-1
1	DTA-DS-13,LSCA-DS-13,DTA-SS-3,DTA-SS-2
1	DTA-DS-14,DTA-DS-14,TVA-SS-3,DTA-SS-1
1	DTA-DS-15,DTA-DS-15,DTA-DS-15,DTA-DS-15,DTA-SS-3
1	DTA-DS-15,DTA-DS-15,DTA-DS-15,DTA-SS-3
1	DTA-DS-15,DTA-DS-15,DTA-DS-15,LSCA-DS-15,DTA-SS-2,DTA-SS-1
1	DTA-DS-15,DTA-DS-15,DTA-SS-1,DTA-SS-1,DTA-SS-1
1	DTA-DS-15,DTA-DS-15,RSCA-DS-15,DTA-SS-3
1	DTA-DS-16,DTA-DS-16,DTA-DS-16,DTA-SS-1,RSCA-SS-1
1	DTA-DS-16,DTA-DS-16,DTA-DS-16,DTA-SS-2
1	DTA-DS-16,DTA-DS-16,DTA-SS-1,DTA-SS-1
1	DTA-DS-16,DTA-DS-16,LSCA-DS-16,DTA-SS-1,DTA-SS-1
1	DTA-DS-16,DTA-DS-16,RSCA-DS-16,RSCA-DS-16,DTA-SS-2
1	DTA-DS-16,RSCA-DS-16,LSCA-SS-2
1	DTA-CSS-18
1	DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,RSCA-DS-18
1	DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,LSCA-DS-18,RSCA-DS-18
1	DTA-DS-18,DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,RSCA-DS-18
1	DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18
1	DTA-DS-18,DTA-DS-18,DTA-DS-18,LSCA-DS-18,RSCA-DS-18,TVA-DS-18
1	DTA-DS-18,DTA-DS-18,DTA-DS-18,RSCA-DS-18
1	DTA-DS-7,DTA-DS-7,DTA-SS-6,RSCA-SS-2,DTA-SS-1,DTA-SS-1
1	DTA-DS-8,DTA-DS-8,DTA-SS-5,DTA-SS-2,DTA-SS-2,DTA-SS-1
1	DTA-DS-8,DTA-DS-8,LSCA-DS-8,DTA-SS-2,DTA-SS-1,DTA-SS-1,DTA-SS-1,DTA-SS-1
1	DTA-DS-9,DTA-DS-9,DTA-SS-9
1	DTA-DS-9,DTA-DS-9,PDA-8,LSCA-SS-1
1	DTA-DS-9,RSCA-DS-9,DTA-SS-5,DTA-SS-4
1	DTA-MS-12,DTA-DS-10,DTA-SS-4,DTA-SS-2
1	DTA-MS-14,DTA-DS-13,LSCA-SS-4
1	DTA-MS-14,DTA-DS-9,DTA-SS-3,DTA-SS-1
1	DTA-MS-15,DTA-DS-11,LSCA-SS-2,LSCA-SS-1
1	DTA-MS-15,DTA-DS-13,RSCA-SS-3
1	DTA-MS-15,DTA-DS-14,DTA-SS-1,DTA-SS-1
1	DTA-MS-15,DTA-DS-14,TVA-DS-14,DTA-SS-2,DTA-SS-1
1	DTA-MS-15,DTA-MS-14
1	DTA-MS-16,DTA-DS-14,DTA-DS-14,LSCA-SS-2
1	DTA-MS-16,DTA-DS-14,DTA-SS-2
1	DTA-MS-16,DTA-MS-14,DTA-DS-12
1	DTA-MS-17,DTA-DS-11,DTA-SS-1
1	DTA-MS-17,DTA-DS-15,DTA-SS-1
1	DTA-MS-17,DTA-DS-15,LSCA-DS-15,DTA-SS-1
1	DTA-MS-18,DTA-DS-14
1	DTA-MS-18,DTA-DS-14,DTA-DS-14,DTA-DS-14
1	DTA-MS-18,DTA-DS-15
1	DTA-MS-18,DTA-DS-17,DTA-DS-17
1	DTA-MS-18,LSCA-DS-15
1	DTA-MS-7,DTA-DS-6,DTA-SS-4,DTA-SS-3,DTA-SS-2,RSCA-SS-2
1	DTA-MS-7,DTA-SS-6,DTA-MS-4,DTA-SS-3,DTA-MS-2
1	DTA-MS-9,DTA-SS-9
1	DTA-SS-10,DTA-SS-4,LSCA-SS-3,DTA-SS-1
1	DTA-SS-10,DTA-SS-5,DTA-SS-1,TVA-SS-1
1	DTA-SS-10,DTA-SS-5,DTA-SS-2,DTA-SS-1
1	DTA-SS-13,DTA-SS-2,DTA-SS-2,DTA-SS-1
1	DTA-SS-4,DTA-SS-3,DTA-SS-3,DTA-SS-2,DTA-SS-2,TVA-SS-2,CA-CSS-1,DTA-SS-1
1	DTA-SS-5,DTA-SS-3,DTA-SS-3,DTA-SS-3,DTA-SS-2,DTA-SS-1
1	DTA-SS-5,DTA-SS-4,DTA-SS-4,DTA-SS-3,RSCA-SS-2
1	DTA-SS-5,DTA-SS-5,DTA-SS-4,LSCA-SS-4
1	DTA-SS-5,DTA-SS-5,DTA-SS-5,DTA-SS-3

1	DTA-SS-5,LSCA-CSS-5,DTA-SS-4,DTA-SS-3,DTA-SS-1
1	DTA-SS-6,DTA-SS-5,DTA-SS-3,DTA-SS-2,DTA-SS-2
1	DTA-SS-6,DTA-SS-5,TVA-SS-3,DTA-SS-2,DTA-SS-2
1	DTA-SS-6,DTA-SS-6,DTA-SS-3,DTA-SS-2,DTA-SS-1
1	DTA-SS-7,DTA-CSS-4,DTA-SS-3,LSCA-SS-2,DTA-SS-1,LSCA-SS-1
1	DTA-SS-7,DTA-SS-4,DTA-SS-4,DTA-SS-3
1	DTA-SS-7,DTA-SS-5,DTA-SS-3,TVA-SS-3
1	DTA-SS-7,DTA-SS-5,LSCA-SS-3,RSCA-SS-3
1	DTA-SS-7,DTA-SS-6,DTA-SS-4,DTA-SS-3
1	DTA-SS-7,DTA-SS-7,DTA-SS-2,DTA-SS-2
1	DTA-SS-7,DTA-SS-7,DTA-SS-3,DTA-SS-1
1	DTA-SS-7,LSCA-SS-6,DTA-CSS-5
1	DTA-SS-8,CA-DS-7,TVA-DS-7,LSCA-SS-2,RSCA-SS-1
1	DTA-SS-8,DTA-CSS-7,DTA-SS-2,DTA-SS-1
1	DTA-SS-8,DTA-CSS-7,DTA-SS-3
1	DTA-SS-8,DTA-SS-4,DTA-SS-4,DTA-SS-1,DTA-SS-1
1	DTA-SS-8,DTA-SS-5,DTA-CSS-4,LSCA-SS-1
1	DTA-SS-8,DTA-SS-5,DTA-SS-3,DTA-SS-2
1	DTA-SS-8,DTA-SS-5,DTA-SS-4,DTA-SS-1
1	DTA-SS-8,DTA-SS-5,DTA-SS-4,LSCA-SS-1
1	DTA-SS-8,DTA-SS-5,DTA-SS-5
1	DTA-SS-8,DTA-SS-6,DTA-SS-4
1	DTA-SS-8,DTA-SS-7,DTA-CSS-3
1	DTA-SS-8,LSCA-SS-5,DTA-SS-3,DTA-SS-2
1	DTA-SS-8,PDA-8,DTA-SS-1,DTA-SS-1
1	DTA-SS-8,TVA-SS-8,DTA-SS-2
1	DTA-SS-9,DTA-CSS-7,DTA-SS-1,DTA-SS-1
1	DTA-SS-9,DTA-CSS-8,LSCA-SS-1
1	DTA-SS-9,DTA-CSS-8,RSCA-SS-1
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1	DTA-SS-9,DTA-SS-8,LSCA-SS-1
1	HT-10,DTA-SS-3,RSCA-SS-2,DTA-SS-1,DTA-SS-1,RSCA-SS-1
1	HT-8,CA-CSS-5,DTA-SS-3,DTA-SS-2
1	HT-8,DTA-SS-4,DTA-SS-3,DTA-SS-2,DTA-SS-1
1	HT-8,DTA-SS-7,DTA-SS-3
1	LSCA-CSS-7,DTA-SS-5,DTA-SS-3,DTA-SS-3
1	LSCA-MS-15,DTA-DS-14,DTA-DS-14,LSCA-SS-2,DTA-SS-1
1	LSCA-MS-18,DTA-DS-15
1	LSCA-MS-18,RSCA-DS-15
1	LSCA-SS-10,DTA-SS-8
1	LSCA-SS-9,DTA-SS-8,DTA-SS-1
1	PDA-10,CA-DS-8,DTA-DS-8
1	PDA-8,CA-DS-4,DTA-DS-4,DTA-SS-3,DTA-SS-2,DTA-SS-1
1	PDA-8,DTA-CSS-6,DTA-SS-4
1	PDA-8,DTA-CSS-7,RSCA-SS-2,DTA-SS-1
1	PDA-8,DTA-SS-4,CA-CSS-3,DTA-SS-3
1	PDA-8,DTA-SS-4,RSCA-SS-4,CA-CSS-2
1	PDA-8,DTA-SS-5,DTA-SS-4,DTA-SS-1
1	PDA-8,DTA-SS-5,RSCA-CSS-3,DTA-SS-2
1	PDA-8,DTA-SS-7,DTA-SS-3
1	PDA-8,RSCA-SS-5,DTA-SS-3,DTA-SS-1,RSCA-SS-1
1	RSCA-CSS-10,TVA-SS-6,DTA-SS-2
1	RSCA-CSS-12,DTA-SS-6
1	RSCA-CSS-7,LSCA-SS-5,DTA-SS-4,DTA-SS-2
1	TVA-SS-9,DTA-CSS-4,DTA-SS-4,DTA-SS-1

Table S1. Classification of MAPCAs and unilateral branch PAs.

MAPCA Number	Number of separate MAPCA origins from the systemic circulation
MAPCA Origin	Left or right subclavian artery (including branches thereof) Transverse aortic arch Descending thoracic aorta Abdominal aorta Coronary artery
MAPCA Course	Leftward (into the left PA at the hilum or lobar or segmental branches) Rightward (into the right PA at the hilum or lobar or segmental branches) Midline (into the intrapericardial PA)
Nature of MAPCA supply	Single supply (no connection to the central PAs) Isolated supply to central PA (only MAPCA connecting to the central PAs) Dual supply (1 of at least 2 MAPCAs connecting to the central PAs) Mixed supply (1 or more single-supply and 1 or more dual-supply branches)
MAPCA segmental supply	Specific lung segments (out of 18) supplied by each MAPCA, either in isolation (single-supply) or via the central PAs (dual-supply)
Unilateral PDA	Arising from a typical PDA location and supplying a normally arborizing unilateral PA, with no MAPCAs to that lung and no intrapericardial PA
Anomalous branch PA	Arising from the ascending aorta, supplying a normally arborizing branch PA, with no MAPCAs to that lung

MAPCA: Major aortopulmonary collateral artery; PA: Pulmonary artery; PDA: Ductus arteriosus

Table S2. Relationship of MAPCA origin to aortic arch sidedness and branching.

	Thoracic aorta MAPCAs	Thoracic aorta MAPCAs only	Subclavian MAPCAs	Abdominal MAPCAs	Coronary MAPCAs	Transverse arch MAPCAs	RSCA & LSCA MAPCAs
All Patients (n=276)	274 (99%)	153 (55%)	105 (38%)	20 (7%)	15 (5%)	15 (5%)	26 (9%)
Arch sidedness							
Left (n=147, 53%)	146 (53%)	78 (51%)	61 (58%)	12 (60%)	8 (53%)	10 (67%)	17 (65%)
Right (n=129, 47%)	128 (47%)	75 (49%)	44 (42%)	8 (40%)	7 (47%)	5 (33%)	9 (35%)
p-value	>0.99	0.47	0.22	0.64	>0.99	0.43	0.22
Arch branching							
Normal (n=232, 84%)	231 (84%)	130 (85%)	85 (81%)	17 (85%)	12 (80%)	14 (93%)	21 (81%)
Abnormal (n=44, 16%)	43 (16%)	23 (15%)	20 (19%)	3 (15%)	3 (20%)	1 (7%)	5 (19%)
p-value	0.29	0.74	0.31	>0.99	0.71	0.48	0.58

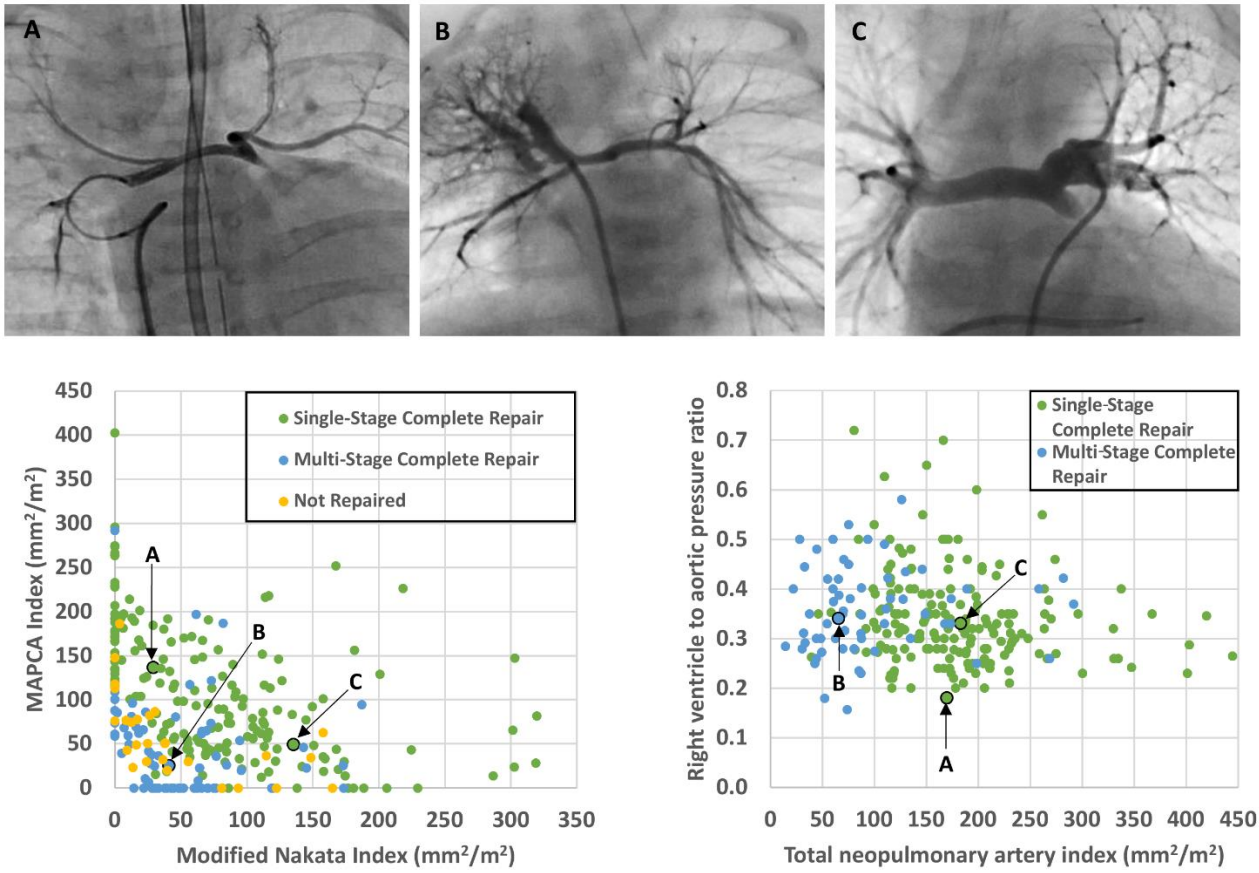
Data presented as n (%). MAPCA: Major aortopulmonary collateral artery, RSCA: Right subclavian artery, LSCA: Left subclavian artery.

Table S3. Relationship between arch sidedness and branching and the presence of MAPCAs from the subclavian arteries.

	Right arch (n=129)	Left arch (n=147)	p-value	Aberrant left SCA (n=35)	Aberrant right SCA (n=9)	p-value
Left SCA MAPCA only	30 (23%)	8 (5%)	<0.001	10 (29%)	1 (11%)	0.22
Right SCA MAPCA only	5 (4%)	36 (24%)	<0.001	1 (3%)	3 (33%)	0.008
Bilateral SCA MAPCAs	9 (7%)	17 (12%)	0.27	4 (11%)	1 (11%)	0.90
No SCA MAPCAs	85 (66%)	86 (59%)	0.26	20 (57%)	4 (44%)	0.34

Data presented as n (%). SCA=subclavian artery; MAPCA=Major aortopulmonary collateral artery

Figure S1. Summary figure.



Left scatterplot: 249 of 276 (90%) patients underwent complete repair, either in 1 (green) or ≥2 (blue) surgeries, and unrepaired (yellow) patients clustered to the left-lower corner, with a paucity of both cross-sectional central PA (modified Nakata index) and MAPCA (MAPCA-index) material. Right scatterplot: Of 249 repaired patients, 182 (73%) underwent repair in 1-stage, and patients that required ≥2 surgeries clustered to the left (blue), with less total cross-sectional PA and MAPCA (TNPAI) material. Angiograms of 3 patients with incompletely arborizing central PAs are shown, with their corresponding positions on the scatterplots noted. Patients A and B had hypoplastic central PAs (low modified Nakata Index). Patient A had a large MAPCA index and underwent single-stage repair, whereas patient B had hypoplastic single-supply MAPCAs and was first palliated with a unifocalization to a central shunt.

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Reintervention Is Associated With Improved Survival in Pediatric Patients With Pulmonary Vein Stenosis

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ABSTRACT

OBJECTIVES The aim of this study was to evaluate survival following catheter intervention in pediatric patients with pulmonary vein stenosis (PVS).

BACKGROUND Despite aggressive surgical and catheter intervention on PVS in children, recurrence and progression of stenosis can lead to right heart failure and death. Clinicians continue to seek effective treatment options for PVS.

METHODS A single-center, retrospective study was performed including all patients <18 years of age who underwent catheter intervention (balloon angioplasty and bare-metal stent and drug-eluting stent insertion) on PVS. Endpoints included death, vein loss, and rate of reintervention.

RESULTS Thirty patients underwent intervention (balloon angioplasty, n = 9; bare-metal stent, n = 5; drug-eluting stent, n = 16) at a median age of 6.4 months (4.3 to 9.9 months). Median follow-up duration was 30.6 months (77 days to 10.5 years). Fourteen patients (47%) died at a median of 2.0 months (0.4 to 3.2 months) following intervention. There was no association between DES placement and survival ($p = 0.067$). Reintervention (catheter or surgical) was associated with improved survival ($p = 0.001$), with a 1-year survival rate of 84% compared with 25% for no reintervention. Vein loss occurred in 34 of 58 (59%) veins at a median of 3.3 months (1.0 to 5.0 months). One-year vein survival was higher with DES implantation ($p = 0.031$) and with reintervention ($p < 0.001$).

CONCLUSIONS DES implantation at first catheter intervention appears to be associated with improved vein survival but may not result in improved patient survival. However, reintervention appears to be associated with improved patient survival and vein patency, suggesting that despite mode of treatment, frequent surveillance is important in the care of these patients. (J Am Coll Cardiol Intv 2017;10:1788–98)

In children, pulmonary vein stenosis (PVS) is uncommon, presenting either as primary (idiopathic) PVS or secondary (post-surgical) PVS, usually following repair of total or partial anomalous pulmonary venous return. PVS is progressive in nature and can result in secondary pulmonary hypertension, right heart failure, and death (1–4). Surgical intervention at some centers is considered the primary treatment for both types of PVS (4). Despite aggressive surgical intervention, PVS is often recurrent (5).

Transcatheter interventions have been used to treat PVS, although outcomes have been variable. Outcomes following balloon angioplasty (BA) for PVS were reported as early as 1982, with poor long-term pulmonary vein (PV) patency (6–8). Stent implantation has also been reported, although many investigators report a high rate of neointimal proliferation within the implanted PV stents (9). The largest study evaluating stent efficacy for PVS in children found stent diameter to be a predictor of freedom from occlusion and reintervention (10).

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Studies looking at adult patients with acquired PVS found stent placement to be superior to BA, especially when larger stents can be deployed (11,12).

Histologic evaluation of PVS pathology suggests that myofibroblastic proliferation contributes importantly to the disease and may play a role in aggressive recurrence (13). Recent reports have suggested that inhibiting proliferation could temper the progression of disease. As a result, many centers have used antiproliferative and anti-inflammatory strategies when treating PVS. Drug-eluting stents (DES), initially introduced to alleviate coronary artery neointimal hyperplasia (14–17), have been implanted in infants and small children with PVS, who have had particularly poor outcomes (1,3,4,10,18). In a porcine model, DES were found to reduce in-stent stenosis compared with bare-metal stents (BMS) when placed in PVs (19). Outcomes following DES implantation in children with PVS are limited to case reports and small series that constitute a subset of larger reviews. The objective of our study was to compare survival following transcatheter intervention, including BA and BMS and DES implantation, in pediatric patients with PVS.

METHODS

PATIENTS. We retrospectively reviewed data from all patients <18 years of age who underwent catheter intervention for PVS from January 2005 to April 2016 at Children's Healthcare of Atlanta. The patients were identified through review of our database of catheterization procedures. Patient characteristics and demographics were noted, including age and weight at first PV intervention, the presence of associated congenital heart disease, and history of prior PV intervention. PV disease was characterized as: 1) unilateral or bilateral; 2) primary or secondary (defined as post-surgical, either for total or partial anomalous pulmonary venous return or primary PVS); 3) and by the number of PVs intervened upon both at index catheter-based intervention and later. Approval was obtained from the Institutional Review Board at Children's Healthcare of Atlanta.

CARDIAC CATHETERIZATION. Techniques and indications for PV dilation and stent implantation have been described previously (20–24). PVS was confirmed during catheterization with pulmonary artery wedge angiography or with directed injections into each PV. Access to the left atrium was through either a patent foramen ovale, atrial septal defect, or via transseptal puncture. Choice of intervention was determined by the operator. Balloon or stent diameter was also determined by the operator, on the basis of the angiographic size of the vessel. Type of DES (i.e., everolimus eluting vs. paclitaxel eluting vs. zotarolimus eluting) was not chosen by the operator for specific immunomodulatory effect, but rather DES type was selected by availability. All digital angiograms from the index case were reviewed.

ABBREVIATIONS AND ACRONYMS

BA = balloon angioplasty
BMS = bare-metal stent(s)
DES = drug-eluting stent(s)
PV = pulmonary vein
PVS = pulmonary vein stenosis
SMD = standardized mean difference

TABLE 1 Patient Characteristics

	Total (n = 30)	DES (n = 16)	BMS (n = 5)	BA (n = 9)	SMD
Demographics					
Male	15 (50)	7 (43)	2 (40)	6 (67)	0.368
Age (months)	6.4 (4.3–9.9)	6.4 (4.3–13.8)	7.0 (2.5–8.9)	6.0 (4.3–12.1)	0.386
Weight (kg)	5.5 (7.9–6.3)	5.9 (5.2–6.4)	4.9 (4.1–5.9)	5.2 (4.7–6.8)	0.475
Preterm (<36 weeks)	14 (47)	6 (43)	2 (40)	6 (75)	0.502
Very preterm (<32 weeks)	10 (33)	3 (21)	2 (40)	5 (63)	0.596
Genetic syndrome	7 (23)	6 (38)	0	1 (11)	0.747
Cardiac disease					
Congenital heart disease*	20 (67)	13 (81)	4 (80)	3 (33)	0.735
Single ventricle	6 (20)	3 (19)	2 (40)	1 (11)	0.466
Bilateral vein disease	11 (36)	6 (38)	3 (60)	2 (22)	0.544
History of TAPVR/PAPVR	12 (40)	6 (38)	4 (80)	2 (22)	0.904
Surgical history					
Previous vein surgery	15 (50)	9 (56)	4 (80)	2 (22)	0.896
Time from first surgery (months)	3.1 (1.3–5.7)	2.5 (0.6–5.7)	2.4 (1.2–4.9)	17.9 (2.9–32.9)	0.744
Time from last surgery (months)	1.4 (1.2–3.4)	1.4 (0.6–2.5)	1.3 (1.1–4.4)	17.7 (2.5–32.9)	0.722
Length of follow-up (months)	4.0 (2.1–37.7)	12.4 (3.2–33.2)	2.5 (1.3–34.3)	3.0 (0.8–47.0)	0.210

Values are n (%) or median (range). *Congenital heart disease necessitating surgery, excluding patent ductus arteriosus.

BA = balloon angioplasty; BMS = bare-metal stent(s); DES = drug-eluting stent(s); PAPVR = partial anomalous pulmonary venous return; SMD = standardized mean difference; TAPVR = total anomalous pulmonary venous return.

TABLE 2 Individual Vein Characteristics

	Total (n = 58)	DES (n = 30)	BMS (n = 10)	BA (n = 18)	SMD
Previous surgery	36 (62)	22 (73)	8 (80)	6 (33)	0.502
Discrete stenosis	42 (72)	21 (70)	9 (90)	12 (67)	0.369
Long segment	16 (28)	9 (30)	1 (10)	6 (33)	0.369
Intervention characteristics					
Stent/balloon diameter (mm)	4.0 (3.5–14.0)	4.0 (3.5–5.0)	5.0 (4.0–12.0)	5.0 (3.0–14.0)	0.890
Measurement of stenosis (mm)	1.7 (1.2–2.2)	1.4 (1.0–2.0)	1.7 (1.6–2.4)	1.8 (1.5–2.5)	0.514
Widest point (mm)	3.7 (3.0–4.4)	3.6 (2.9–4.1)	3.9 (3.2–5.0)	4.2 (3.5–5.3)	0.534
Post-intervention measurement (mm)	3.5 (3.2–4.1)	3.6 (3.4–3.9)	4.9 (3.8–5.4)	3.3 (2.5–3.7)	0.201
Reinterventions					
>1 catheter-based intervention	22 (38)	15 (50)	4 (40)	3 (16.7)	0.581
>1 total interventions*	24 (41)	16 (53)	4 (40)	4 (22)	0.480
Surgery after catheter intervention	8 (14)	5 (17)	0	3 (17)	0.516

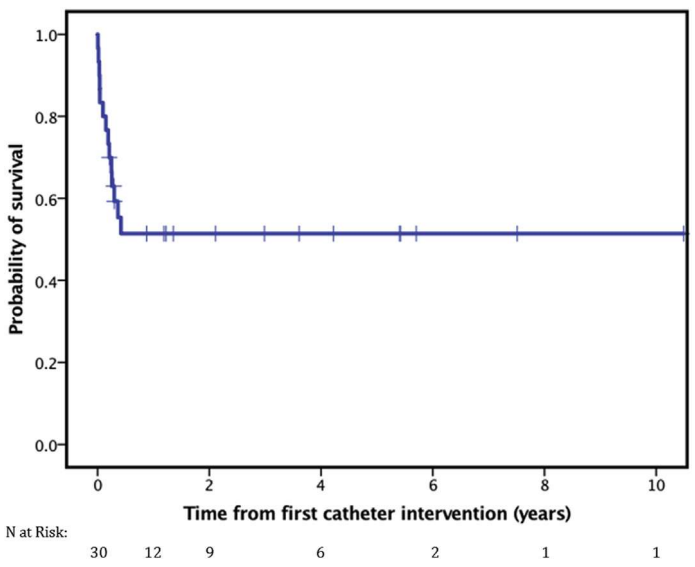
Values are n (%) or median (absolute range). *Includes first catheter intervention and any surgery or catheter intervention following the first catheter intervention.
Abbreviations as in Table 1.

Areas of obstruction were classified as discrete or long segment. Measurement of the area of stenosis was made before and after angioplasty or stent placement. For long-segment stenosis, the location of the balloon or stent waist was used as the site of vessel measurement.

DATA ANALYSIS. Patient demographics, diagnosis, mortality, and total reintervention were reported with each patient (i.e., not each treated PV) as the index unit. Rate of atresia and reintervention on individual veins were reported with the stented or angioplastied vein as the index unit.

The primary outcome assessed was mortality following transcatheter PV intervention. Secondary outcomes included PV reintervention (both transcatheter and surgical) and vein loss (a composite of vein atresia or patient death). For the purpose of testing the hypothesis that immunomodulatory stents (i.e., DES) have superior efficacy, the cohorts undergoing BMS implantation and undergoing BA were combined as the "nonimmunomodulatory" cohort. Data are expressed as median (interquartile range) or as number (percentage). When comparing 2 variables, categorical variables were analyzed using the Fisher exact test, and nonparametric continuous variables were assessed using the Mann-Whitney *U* test. Time-dependent survival analyses were performed using Kaplan-Meier log rank analysis. A p value of <0.05 was considered to indicate statistical significance. Data analysis for 2 variables was performed using SPSS version 23.0 (IBM, Armonk, New York). When comparing 3 variables, standardized mean differences (SMD) were calculated in R version 3.3.2 using the package "tableone" (R Foundation for Statistical Computing, Vienna, Austria). An SMD of <0.49 was considered a slight or small difference, an SMD of 0.50 to 0.79 was considered a moderate difference, and an SMD >0.80 was considered a large difference.

FIGURE 1 Patient Survival



Survival curve for all patients demonstrates rapid decline in survival in the first year post-intervention but stabilization past 1 year.

RESULTS

Between 2005 and 2016, 30 patients underwent catheter-based intervention for PVS at a median age

of 6.4 months (4.3 to 9.9 months). Fifteen of the patients (50%) had undergone previous surgical PV repair, including total or partial anomalous pulmonary venous return repair (n = 12 [40%]) and surgical repair of primary PVS (n = 3 [10%]). The remaining 15 patients (50%) underwent primary catheter intervention, and these patients were all diagnosed with idiopathic PVS.

Among the 30 patients, 9 (30%) underwent BA, 5 (17%) underwent BMS implantation, and 16 (53%) underwent DES implantation. Four patients (13%) had multiple therapies for different PVs at initial catheter-based intervention. Demographic data are summarized in Table 1.

Among the 30 patients, 58 individual veins were intervened upon, with a median of 2 (range 1 to 5) PVs per patient. The veins were characterized as either discrete (n = 42 [72%]) or long segment (n = 16 [28%]). Thirty veins (52%) underwent DES implantation. The DES agents included everolimus (n = 21 [70%]), zotarolimus (n = 7 [23%]), and paclitaxel (n = 2 [7%]). Ten veins (17%) underwent BMS implantation, and 18 (31%) underwent BA alone. Only 1 patient underwent cutting BA of a single PV; the remaining BA interventions used conventional balloons. The DES were smaller in diameter than the BMS and balloons for BA (SMD = 0.890) (Table 2). Although the DES had smaller diameters than the balloons used for BA, veins that underwent BA had smaller immediate post-intervention diameters than veins that underwent DES or BMS implantation (SMD = 0.201) (Table 2). There was no difference in the rate of reintervention by manner of catheter intervention. Vein intervention characteristics are summarized in Table 2. Detailed information on intervention type provided in Online Table 1.

MORTALITY. Follow-up duration for the cohort was a median of 30.6 months (range 77 days to 10.5 years). Fourteen patients (47%) died at a median of 2.0 months (0.4 to 3.2 months) following intervention. The causes of death for all of these patients were directly related to PVS, including right heart failure, pulmonary hypertension, and respiratory failure. Overall survival rates at 1 month and 1 year were 83% and 51%, respectively (Figure 1). Mortality was not associated with age or weight at first catheter-based intervention, single-ventricle physiology, bilateral vein involvement, or prior surgical intervention. There was also no significant association between intervention type and mortality. Survival was better in patients who underwent repeat intervention (surgical or catheter based) following primary catheter

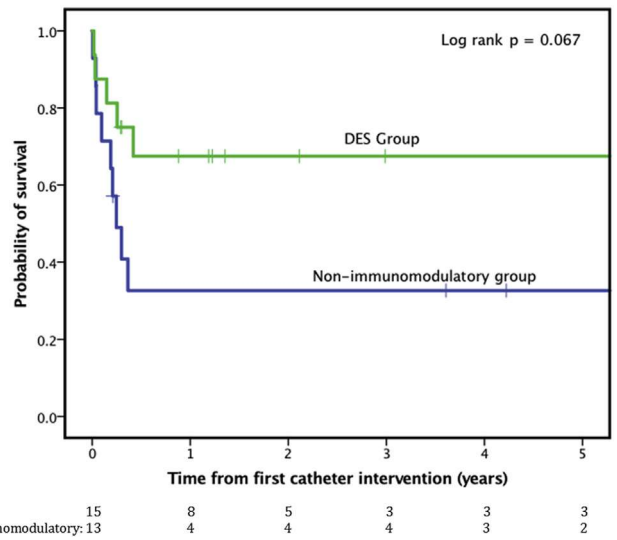
TABLE 3 Univariate Analysis of All-Cause Mortality

	Total (N = 30)	Deceased (n = 14)	Alive (n = 16)	p Value
Demographics				
Age (months)	6.4 (4.3–9.9)	5.9 (3.8–9.6)	7.7 (4.4–13.8)	0.377
Weight (kg)	5.5 (7.9–6.3)	5.1 (4.6–6.0)	5.8 (5.2–6.4)	0.142
Preterm (<36 weeks)	14 (47)	8 (67)	6 (40)	0.252
Very preterm (<32 weeks)	10 (33)	7 (58)	3 (20)	0.057
Genetic syndrome	7 (23)	2 (14)	5 (31)	0.399
Cardiac disease				
Congenital heart disease*	20 (67)	7 (50)	13 (81)	0.122
Single ventricle	6 (20)	2 (14)	4 (25)	0.657
Bilateral vein disease	11 (36)	5 (36)	6 (38)	>0.999
History of TAPVR/PAPVR	12 (40)	4 (29)	8 (50)	0.284
Surgical history				
Previous vein surgery	15 (50)	6 (43)	9 (56)	0.715
Time from first surgery (months)	3.1 (1.3–5.7)	1.5 (0.9–3.3)	4.4 (1.8–15.7)	0.181
Time from last surgery (months)	1.4 (1.2–3.4)	1.3 (0.9–1.4)	2.6 (1.3–15.5)	0.059
Catheter intervention				
DES placed at first intervention	16 (53)	5 (36)	11 (69)	0.141
>1 catheter-based intervention	12 (40)	2 (14)	10 (63)	0.011
>1 total intervention†	14 (47)	2 (14)	12 (75)	0.001
Surgery after catheter intervention	5 (17)	0 (0)	5 (31)	0.045
Time between interventions (months)‡	3.7 (2.1–8.2)	1.6 (0.8–2.4)	4.8 (2.5–9.3)	0.088

Values are median (range) or n (%). Categorical variables were analyzed using the chi-square test, and continuous variables were analyzed using the Mann-Whitney *U* test. *Congenital heart disease necessitating surgery, excluding patent ductus arteriosus. †Includes first catheter intervention and any surgery or catheter intervention following the first catheter intervention. ‡Includes all interventions (surgical and catheter) after first catheter intervention.

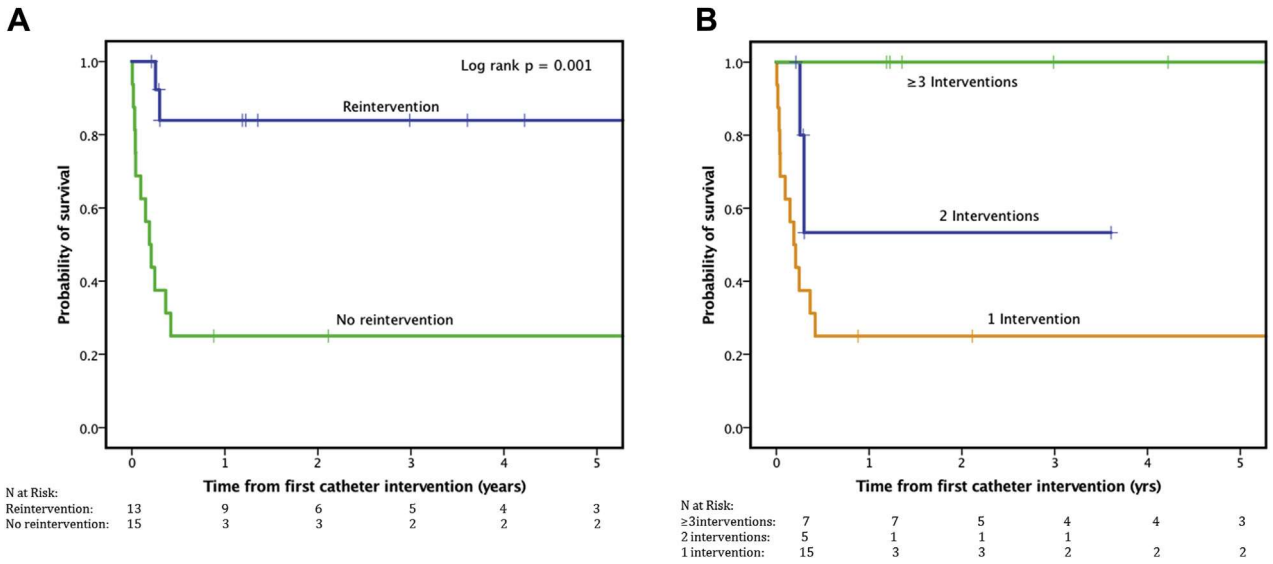
Abbreviations as in Table 1.

FIGURE 2 Patient Survival: Intervention Type



Kaplan-Meier analysis comparing survival of patients who received drug-eluting stents (DES) against patients who received either balloon angioplasty or bare-metal stents (nonimmunomodulatory therapy).

FIGURE 3 Patient Survival: Reintervention



(A) Kaplan-Meier analysis comparing survival between patients who underwent catheter and/or surgical reintervention and patients who did not undergo reintervention demonstrates improved survival with reintervention. **(B)** Kaplan-Meier analysis comparing survival on the basis of the number of catheter and/or surgical interventions from the first catheter intervention. Survival appears to improve with increasing number of interventions.

intervention (p = 0.001). Mortality data are summarized in Table 3.

The DES cohort was compared with patients undergoing BA and BMS placement, who combined were considered the nonimmunomodulatory cohort in a Kaplan-Meier survival analysis. The survival rates at 1 year were 68% for the DES group and 33% for the nonimmunomodulatory group (log-rank p = 0.067) (Figure 2).

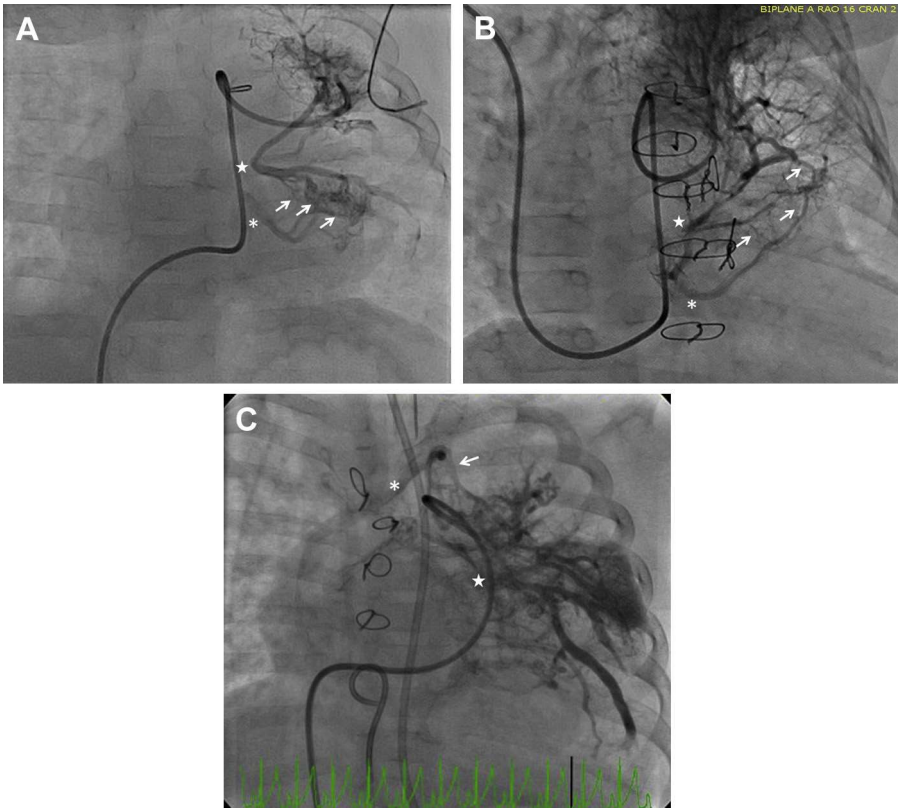
The survival rate at 1 year for patients who underwent reintervention (surgical or catheter) was 84% compared with 25% for patients who did not undergo reintervention (log-rank p = 0.007). The relative risk for 1-year survival in patients who underwent reintervention compared with those who did not was 4.09 (95% confidence interval: 1.43 to 11.69). This survival advantage was found to be greater with increasing number of interventions, with survival rate at 1 year of 100% in patients with ≥3 interventions, 53% in patients with 2 interventions, and 25% in patients with 1 intervention (Figures 3A and 3B).

In an attempt to understand if reintervention was truly protective against mortality or if survivors merely were afforded an opportunity for reintervention, we excluded patients who died within 1 month of primary catheter intervention and performed Kaplan-Meir analysis on the remaining cohort. This was based on our clinical practice of encouraging repeat catheterization 6 weeks after initial intervention. This analysis likewise demonstrated a survival advantage in patients who underwent reintervention, with a 1-year survival rate of 84% compared with 36% in patients who did not undergo reintervention (log-rank p = 0.013).

ATRESIA. Among the 31 veins in 16 survivors, 7 veins (22%) were found to be atretic in 7 patients (44%). Atresia was noted by angiography and occurred at a median time of 12.1 months (7.3 to 31.2 months). One of the patients who developed left upper and lower PV atresia ultimately underwent pneumonectomy because of recurrent, severe hemoptysis. In 2 of the 14 patients who died, 4 of 27 veins (15%) had previously been noted to be atretic by angiography before death. Hence, a total of 11 veins in 9 patients became atretic following intervention; the median time to discovery of atresia in these 11 veins was 7.3 months (2.1 to 14.8 months). Ten patients who died did not undergo repeat catheterization following the intervention and thus had no documentation of the status of the PV at the time of death.

Of the 9 patients with documented atresia, 7 (78%) had evidence of decompressing collateral formation

FIGURE 4 Collateral Formation



(A) Patient #1: angiogram demonstrating left upper pulmonary vein atresia **(star)** with decompressing interlobar pulmonary venovenous collateral vessels **(arrows)** to the patent left lower pulmonary vein **(asterisk). (B)** Patient #2: angiogram demonstrating atresia of the previously stented left upper pulmonary vein **(star)** with decompressing interlobar pulmonary venovenous collateral vessels **(arrows)** to the stenotic left lower pulmonary vein, which had previously been stented **(asterisk). (C)** Patient #3: angiogram demonstrating left upper pulmonary vein atresia **(star)** with a vertical decompressing pulmonary vein–to–systemic vein collateral vessel **(arrow)** to the innominate vein **(asterisk).**

by angiography. Collateral formation included interlobar pulmonary venovenous collateral vessels (n = 4) (Figures 4A and 4B) and PV-to-systemic vein collateral vessels (n = 3) (Figure 4C). Of the 7 patients with collateral formation, 5 (71%) were alive at most recent follow-up.

Vein loss, defined as actual PV atresia or PVs of uncertain status in deceased patients, occurred in 34 veins (59%) at a median time of 3.3 months (1.0 to 5.0 months). Overall vein patency rates at 1 month and 1 year were 86% and 44%, respectively. Vein loss was not associated with type of stenosis (discrete or long segment), intervention type, stent or balloon diameter, or pre-intervention measurement of stenosis. Post-surgical PVS and veins that had larger post-intervention measurements were associated with vein survival ($p = 0.03$ and $p = 0.013$, respectively). Consistent with overall patient mortality, veins that underwent reintervention (catheter based or surgical) had lower rates of vein loss ($p < 0.001$). Vein survival is summarized in Table 4.

The vein survival rate at 1 year for individual veins that underwent more than 1 procedure was 88% compared with a 1-year survival rate of 18% for veins that did not undergo reintervention (log-rank $p < 0.001$). The relative risk for 1-year vein survival when a vein had more than 1 intervention was 5.00 (95% confidence interval: 2.37 to 10.55) compared with the veins that had only 1 catheter intervention. This survival advantage was again noted to be associated with increasing number of interventions, with 1-year survival for veins undergoing ≥3 procedures of 100% compared with 75% for 2 procedures and 18% for 1 procedure (Figures 5A and 5B).

TABLE 4 Univariate Analysis of Vein Survival

	Total (n = 58)	Vein Loss (n = 34)	Patent (n = 24)	p Value
Vein characteristics				
Previous surgery	36 (62)	17 (50)	19 (79)	0.030
Discrete stenosis	42 (72)	24 (71)	18 (75)	0.773
Long segment	16 (28)	10 (29)	6 (25)	0.773
Intervention characteristics				
First intervention DES	30 (52)	15 (44)	15 (63)	0.192
Stent/balloon diameter (mm)*	4.0 (3.5–14.0)	4.0 (3.5–8.0)	4.0 (3.0–14.0)	0.937
Measurement of stenosis (mm)	1.7 (1.2–2.2)	1.7 (1.4–2.1)	1.6 (1.0–2.2)	0.654
Pre-intervention widest point (mm)	3.7 (3.0–4.4)	3.6 (2.8–4.2)	4.1 (3.5–5.1)	0.067
Post-intervention measurement (mm)	3.5 (3.2–4.1)	3.5 (3.1–3.8)	3.8 (3.5–4.1)	0.013
Reinterventions				
>1 catheter intervention	22 (38)	3 (9)	19 (79)	<0.001
>1 total intervention†	24 (41)	4 (12)	20 (83)	<0.001
Surgery after catheter intervention	8 (14)	1 (12.5)	7 (29)	0.007

Values are n (%) or median (range). Categorical variables were analyzed using the chi-square; continuous variables were analyzed using the Mann-Whitney *U* test. *Median (absolute range). †Includes first catheter intervention and any surgery or catheter intervention following the first catheter intervention.

DES = drug-eluting stent(s).

When comparing vein loss by intervention type, 1-year vein survival in PVs treated with primary DES implantation was higher than PVs treated with BA or BMS (nonimmunomodulatory group) (59% vs. 26%, log-rank p = 0.031) (Figure 6).

REINTERVENTION. Fourteen patients (47%) underwent a total of 25 reinterventions, including additional DES placement (n = 5 [20%]), BMS placement (n = 2 [8%]), stent dilation or BA (n = 13 [52%]), and PV surgery (n = 5 [20%]) for recurrent PVS. Among the patients who had surgical reintervention, 3 patients initially had catheter reintervention ultimately followed by surgical PV repair, and 2 patients had surgical PV repair after first catheter-based intervention. Surgery included pericardial well procedure in all 5 patients with stent removal in all 3 patients with existing PV stents. In the 12 patients who underwent catheter reintervention, 19 veins were reintervened upon because of recurrent stenosis, and 5 of these patients had new vein involvement that required intervention. Median time to first reintervention was 3.1 months (2.2 to 7.0 months).

Within the DES cohort, 8 of 16 patients (50%) underwent catheter reintervention, and 3 of 16 patients (18%) had PV surgery, with a median time between interventions of 3.5 months (1.3 to 7.7 months) after DES placement. Within the BMS cohort, 3 of 5 patients (60%) underwent catheter reintervention, with a median of 2.4 months (2.4 to 17.5 months) between interventions. Within the BA cohort, 1 of 9 patient (11%) underwent catheter reintervention, and 2 of 9 patients (22%) underwent PV surgery, with a median time between interventions of 4.8 months (3.9 to 5.7 months). Rates of reintervention are summarized in Table 5. Reintervention rates within individual veins are summarized in Table 6.

When looking at rates of surveillance following the initial catheter intervention, 19 patients (63%) had at least 1 follow-up catheterization at a median of 2.9 months (2.1 to 3.3 months). At first follow-up catheterization, only 8 of 19 patients (42%) underwent a reintervention, and 2 of these 8 patients required intervention on newly affected veins. The remaining 11 patients (58%) did not undergo repeat intervention at first follow-up catheterization. The time to first catheterization was no different in patients who underwent reintervention (2.4 months [2.1 to 3.1 months]) compared with those who only had diagnostic catheterization (2.9 months [2.1 to 5.9 months]) (p = 0.351). There was no difference in mortality among the patients who had an intervention (n = 2 of 8 [25%]) at first follow-up catheterization compared with those who did not have an intervention (n = 2 of 11 [18%]) (p = 0.999); however, vein survival was greater in veins that underwent intervention at first follow-up catheterization (p = 0.04). Rates of reintervention are summarized in Table 5.

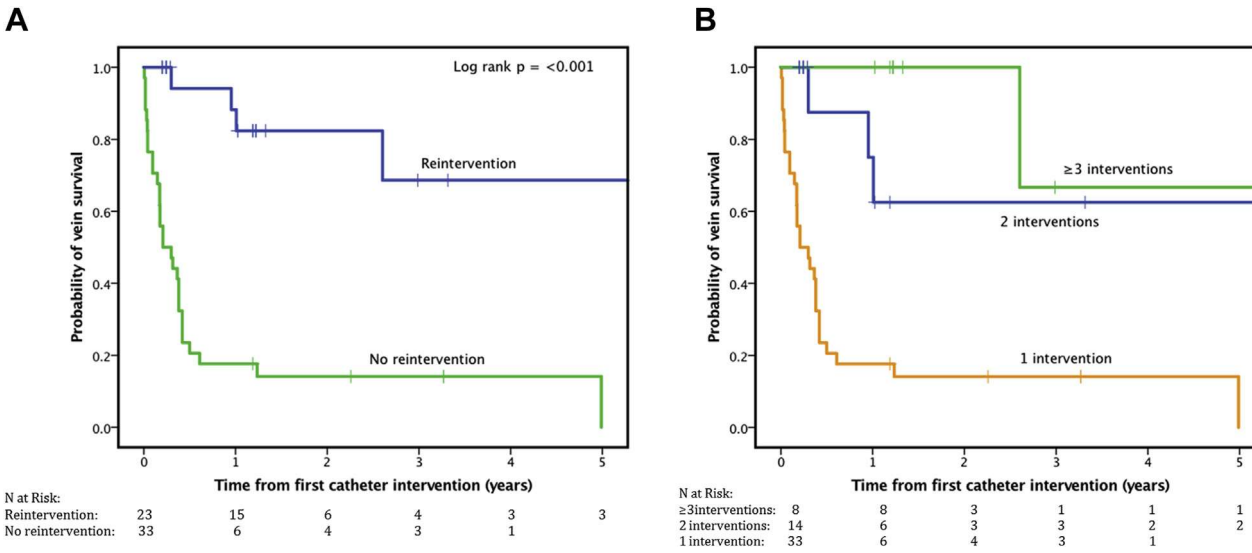
DISCUSSION

This retrospective study was undertaken to evaluate the outcomes of children who underwent catheter-based intervention for PVS. We had a relatively large cohort of pediatric patients at a single institution with both primary and post-surgical PVS. Although many different types of intervention have been attempted for PVS, all of our patients underwent BA, BMS placement, or DES placement.

Our patient population was diagnosed with PVS at a young age, which has been shown in previous studies to be an independent predictor of increased mortality compared with older age at diagnosis (8,18,25). Similar to prior studies, single-ventricle physiology was not associated with increased mortality in our patient population. Interestingly, our data indicated that the presence of bilateral PVS was not associated with mortality. This finding is different from previous publications, which indicate that diffuse, bilateral PVS is a risk factor for mortality (5,18,25).

Although transcatheter procedures for PVS have historically been thought of as primarily palliative (1,4), we have shown reasonable outcomes in our patients who underwent DES placement. Consistent with previous reports, BA alone was shown to be

FIGURE 5 Vein Survival: Reintervention

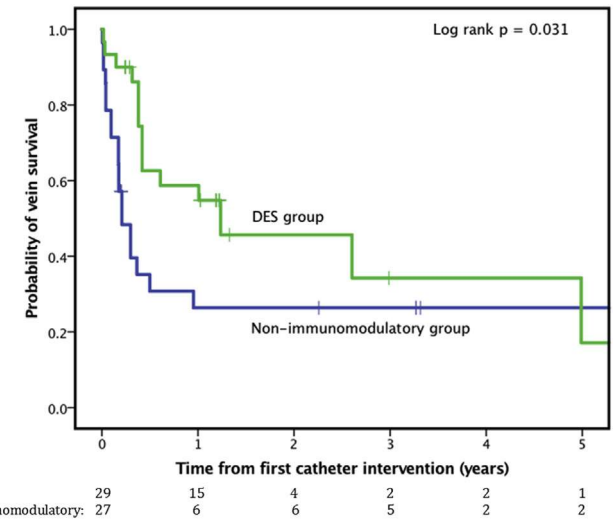


(A) Kaplan-Meier analysis comparing survival between veins that underwent catheter and/or surgical reintervention and veins that did not undergo reintervention demonstrates improved vein survival in veins that underwent reintervention. **(B)** Kaplan-Meier analysis comparing vein survival on the basis of the number of catheter and/or surgical interventions from the first catheter intervention. Vein survival appears to improve with increasing number of interventions.

acutely successful, but midterm success is limited (6,8,11,20). Our survival analysis shows early mortality with all types of transcatheter interventions and stable survival beyond 6 months from intervention. Once patients reach 1 year post-intervention, survival appears likewise to stabilize. We found that patients who return for surveillance catheterization and undergo reintervention, when indicated, have improved survival than those who do not. Because of this, rates of reintervention in our patient population for all intervention types are high in survivors, which is consistent with previous reports (6,9,10). The early mortality we have seen in all intervention types in combination with the survival advantage we found in patients who receive reintervention, would suggest that early routine surveillance catheterization should be undertaken so that restenosis can be detected and intervened on early. However, our study is not powered to determine the precise relationship between reintervention and survival. That is, reintervention may reasonably be considered an important element in the transcatheter approach to PVS to maintain or optimize PV patency. In contrast, one could argue that the survival bias colors the current analysis and that nonsurvivors never had an opportunity for reintervention. Our focused analysis excluding early post-intervention mortality was aimed at addressing this significant limitation and also showed improved survival in patients who underwent reintervention.

Although mortality rates decreased significantly by 1 year post-intervention, the rates of vein loss persisted beyond 1 year. That vein loss rates do not mirror survival is interesting and, perhaps, indicates

FIGURE 6 Vein Survival: Intervention Type



Kaplan-Meier analysis comparing vein survival in veins treated with drug-eluting stents (DES) against balloon angioplasty or bare-metal stents (nonimmunomodulatory therapy).

TABLE 5 Reintervention by Patient

	Total (n = 30)	DES (n = 16)	BMS (n = 5)	BA (n = 9)	SMD
Number of catheter interventions*	1 (1–4)	2 (1–4)	2 (1–3)	1 (1–2)	0.723
Number of total interventions*	1 (1–4)	2 (1–4)	2 (1–3)	1 (1–3)	0.573
>1 catheter intervention	12 (40)	8 (50)	3 (60)	1 (11)	0.774
>1 total intervention†	14 (47)	9 (56)	3 (60)	2 (22)	0.550
Surgery after catheter intervention	5 (17)	3 (19)	0 (0)	2 (22)	0.507
Time between interventions (months)‡	3.7 (2.1–8.2)	3.5 (1.3–7.7)	2.4 (2.4–17.5)	4.8 (3.9–5.7)	0.405

Values are median (range) or n (%). *Median (total range). †Includes first catheter intervention and any surgery or catheter intervention following the first catheter intervention. ‡Includes all interventions (surgical and catheter) after first catheter intervention.

Abbreviations as in Table 1.

intrinsic compensation to PVS and atresia. The late and possibly gradual development of PV atresia may provide sufficient time for the patient to develop venovenous collateral vessels to compensate for the change in their physiology, as we noted in 5 of our survivors with documented atresia. This collateralization may in fact be protective; however, our study is insufficiently powered to address this question.

Balasubramanian et al. (10) showed that a stent diameter >7 mm was a predictor of patency following stent placement for PVS (10). Accordingly, adult studies have also shown a size-dependent success rate for larger stents (11,12). Although it is likely beneficial, with regard to rates of restenosis and the need for reintervention, to have a larger stent diameter, there are situations in which patients have small vessels that cannot accommodate a larger stent. That was, of course, the case in the majority of our patients. The majority of stents placed in our patient population were coronary stents, with only 1 stent >7 mm in diameter. We were interested in success rates in different types of stents and/or BA. Although we did not evaluate stent diameter as a marker of success, the median stent lumen and balloon diameter among the groups was similar, so the survival rate is primarily showing the difference between the interventions as opposed to size.

There is an inherent limitation to DES due to the small maximum luminal diameter in currently available DES, which have a maximal rated diameter of 4.0 mm. In our study, DES implantation appears to be superior to BMS implantation or BA when assessing the rate of vein loss. This suggests that the immunomodulatory effects of DES may be beneficial for PVS when comparing with BMS of similar diameter. This is consistent with previous reports in adult coronary studies and a porcine model with stented PVs, which demonstrated decreased in-stent stenosis in DES compared with BMS (16,19). Additionally, the pathological evaluation by Sadr et al. (13) showing myofibroblastic proliferation as the etiology of PVS suggests that antiproliferative therapy would provide benefit to patients with PVS. The local release of antiproliferative drugs with DES may attenuate the progression of disease, resulting in improvement in survival. Although the mechanism of PVS in adults is different from that in our pediatric population, De Potter et al. (26) also found DES to be an effective treatment in adults for PVS following radiofrequency ablation despite the limitation in the stent luminal

TABLE 6 Reintervention by Individual Vein

	Total (n = 58)	DES (n = 30)	BMS (n = 10)	BA (n = 18)	SMD
Number of catheter interventions*	1 (1–4)	1 (1–4)	1 (1–3)	1 (1–2)	0.800
Number of total interventions*	1 (1–4)	2 (1–4)	1 (1–3)	1 (1–2)	0.565
>1 catheter intervention	22 (38)	15 (50)	4 (40)	3 (17)	0.581
>1 total intervention†	24 (41)	16 (53)	4 (40)	4 (22)	0.480
Surgery after catheter intervention	8 (14)	5 (17)	0 (0)	3 (17)	0.516
Time between interventions (months)‡	3.4 (2.3–7.3)	3.6 (2.1–7.3)	2.4 (2.2–25.0)	4.5 (2.8–19.4)	0.701

Values are median (range) or n (%). *Median (absolute range). †Includes first catheter intervention and any surgery or catheter intervention following the first catheter intervention. ‡Includes all interventions (surgical and catheter) after first catheter intervention.

Abbreviations as in Table 1.

diameter. More studies will need to be undertaken to further evaluate the efficacy of DES for inhibiting the progression of PVS. This observation also suggests that it may be warranted to evaluate drug-eluting balloons as a therapy for PVS, as this may provide the benefit of delivering antiproliferative drugs to the site of injury without the inherent limitation of a small luminal diameter with DES.

STUDY LIMITATIONS. As this was a retrospective study, the patients were not randomized to each intervention type. There were no standardized criteria for intervention on the stenotic PVs, and we were unable to control for interoperator variability and decision making, including which veins to intervene on and which method to use; however, at our institution, surgical repair of PVS is usually considered first-line. All post-surgical patients included in our study were discussed with the surgical team regarding candidacy for surgical repair of PVS before undergoing catheter-based intervention. Additionally, we were unable to control for both practitioner- and patient-specific factors that resulted in variations in follow-up time. Our overall sample size was small, but for this rare disease entity, this is a relatively large cohort that has undergone catheter-based intervention for PVS.

CONCLUSIONS

Children with pulmonary vein stenosis are at risk for post-intervention mortality. Reintervention appears to confer a significant survival benefit to this at-risk population. We were unable to find a survival benefit associated with use of drug-eluting stents. Clearly this disease process would benefit from the conductance of a large, multicenter study.

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PERSPECTIVES

WHAT IS KNOWN? PVS in pediatric patients is a progressive disease that is difficult to treat. Evaluation of catheter-based intervention has been limited and has shown suboptimal survival in pediatric patients.

WHAT IS NEW? Despite size limitations of DES, this intervention is a reasonable treatment option in pediatric patients with PVS. Frequent surveillance catheterization is important to identify the need for reintervention early when restenosis occurs, as this may help improve survival in these patients.

WHAT IS NEXT? Because of the limited studies available, larger multicenter trials would be beneficial in the further evaluation of catheter-based intervention on PVS in pediatric patients. Additionally, evaluation of newer modalities, including drug-eluting BA, should be further evaluated.

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KEY WORDS balloon angioplasty, drug-eluting stent(s), endovascular stent(s), pulmonary vein stenosis

APPENDIX For a supplemental table, please see the online version of this article.

A Review of the Management of Pulmonary Atresia, Ventricular Septal Defect, and Major Aortopulmonary Collateral Arteries

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Background. **The management of pulmonary atresia with ventricular septal defect (PA/VSD) and major aortopulmonary collateral arteries (MAPCAs) has significantly changed over the past 20 years. Unifocalization and rehabilitation have been described as diametrically opposed strategies. An updated review focused on the management of this complex and rare condition is needed.**

Methods. **Articles related to PA/VSD/MAPCAs issued until December 2017 were screened. Twelve main studies published in the modern era (since 2000) were selected and analyzed.**

Results. **Unifocalization and rehabilitation respectively focus on the mobilization of collateral arteries and the growth of native pulmonary vessels. A third strategy, called "combined strategy," was distinguished from the review of the literature. Surgical cohorts and methods of data reporting were found to be heterogenous. Outcomes, regardless of the strategy, have transformed the natural history of the condition, with a complete repair rate of approximately 80% and low rates of early and late mortality. Patients with the most unfavorable anatomy (absent central pulmonary arteries and hypoplastic MAPCAs) remain a challenge and are still left palliated.**

Conclusions. **Variable surgical strategies are used in the management of PA/VSD/MAPCAs. Most teams report a repair rate of 70% to 80% and a mortality rate lower than 10%. Standardization in data reporting is necessary to better compare the existing strategies.**

(Ann Thorac Surg 2019;108:601–12)

Pulmonary atresia with ventricular septal defect (PA/VSD) is the extreme form of the spectrum of tetralogy of Fallot (TOF) [1], with an incidence of 0.07 per 1,000 live births that accounts for approximately 2.5% of all congenital heart diseases. The majority of cases have a normally developed pulmonary blood supply, but 20% to 40% of cases will have multifocal blood supply to the lungs—through major aortopulmonary collateral arteries (MAPCAs). This combination of PA/VSD/MAPCAs is sometimes referred to as "complex pulmonary atresia" and has been difficult to classify owing to the wide variation in pulmonary blood supply in this rare condition. The condition is part of the family of conotruncal anomalies (which includes TOF, truncus arteriosus, and transposition), and as many as half the cases are associated with CATCH 22 syndrome (cardiac defects, abnormal facial features, thymic hypoplasia, cleft palate, hypocalcemia, and 22q11 microdeletion) [2].

The recent classification of the Congenital Heart Surgery Nomenclature and Database Project [1] (similar to the one of Barbero-Marcial and Jatene [3] in 1990) distinguishes three types of PA/VSD according to the pulmonary circulation: type A with present native pulmonary arteries (NPAs) and no MAPCAs; type B with present NPAs and MAPCAs; and type C with MAPCAs only. Although that goes some way to recognize the heterogeneity of pulmonary blood flow in this condition, there is a need for a more detailed and specific classification system that can be correlated to the management strategies available.

MAPCAs are most commonly associated with PA/VSD but can also be found in other congenital heart diseases [4]. The first mention is attributed to Macartney and colleagues [5] in 1973. An angiographic study published by the Melbourne team found similarities with bronchial arteries, but the nature and origin of MAPCAs is still debated [6, 7]. Most MAPCAs have a thoracic origin (descending aorta and subclavian arteries), but these collaterals can also more rarely arise from cervical vessels [8], the abdominal aorta, and even from the coronary arteries [9]. The number, size, distribution, and course of

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Abbreviations and Acronyms

MAPCA = major aortopulmonary collateral artery
NPA = native pulmonary artery
PA = pulmonary artery
PA/VSD = pulmonary atresia with ventricular septal defect
pLV = left ventricle pressure
pPA = pulmonary artery pressure
pRV = right ventricle pressure
RV = right ventricle
TOF = tetralogy of Fallot

the MAPCAs—as well as their relationship with any NPA system—is at the core of the heterogeneity of the condition. This article seeks to clarify and classify this spectrum.

The successful repair of "simple" PA/VSD was first reported by Lillehei and colleagues [10] in 1955, but the concept of the surgical MAPCAs management did not develop until 3 decades later. Even by 1995, only 25 % of PA/VSD/MAPCAs patients survived to adulthood [11]. However, thanks to the pioneering hemodynamic and histopathologic studies of Macartney, Thiene, Haworth, and their colleagues [12–20] in the 1970s and 1980s, surgical strategies and management have radically changed such that the majority of patients now survive into adulthood with good functional class.

Different philosophies currently exist regarding the best management of this complex and heterogenous group of patients; these will be defined and discussed in this article.

After more than 30 years of surgical experience, an updated review is needed on this difficult and nonconsensual topic. Part of the difficulty comes from the small size of most cohorts and from a confusing terminology. The main objective of this article is to focus on the current surgical management strategies of PA/VSD/MAPCAs (ie, PA/VSD types B and C) and their outcomes. Of note, heart-lung transplantation has been suggested [21, 22] as an option, but this technique will not be discussed in this review as it has been marginally reported and it is not recommended in a routine practice.

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Material and Methods

A literature search was performed in December 2017 in PubMed and the Cochrane Library for "pulmonary atresia ventricular septal defect," "aortopulmonary collateral," "pulmonary atresia aortopulmonary collateral," and "tetralogy Fallot aortopulmonary collateral." Only publications in English related to PA/VSD/MAPCAs were analyzed.

Table 1 lists the main studies on the surgical management of patients with PA/VSD/MAPCAs published in the recent era, namely, since year 2000, and constitutes the core of this review. The year 2000 also refers to the year of publication of a landmark article by the Stanford group [23]. This report was an update from another work published 5 years earlier [24] with a cohort of 10 patients that advocated for a midline one-stage repair and unifocalization of PA/VSD/MAPCAs for the first time.

Publications were included in Table 1 according to the following criteria: most recent study by a same institution for a same strategy; consecutive (nonselected) patients with PA/VSD/MAPCAs; overall number of patients in a cohort 30 or more; cohort treated at a single institution; and management toward a biventricular repair.

An exception was made for the article of Bauser-Heaton and colleagues [25]: the study included patients with TOF/pulmonary stenosis and 36% of their patients had previous surgical procedures performed in other institutions. However, the percentage of TOF/pulmonary stenosis was minimal (7.4%), and the management of patients after referral from other institutions was standardized. This exception was also justified by the remarkable size of the cohort (n = 458). Of note, the studied population did not overlap the one from the study of 2000 [23] by the same group (1992 to 1998 versus 2001 to 2016).

Data were extracted when available or calculable (palliation rates).

Results

The largest experiences published for this condition come from Stanford, Birmingham (UK), Melbourne, and Toronto. It has been usual to classify the surgical treatment of PA/VSD/MAPCAs in two dominant and overlapping strategies—unifocalization and rehabilitation—according to the individual pattern and management of MAPCAs. The two concepts are not mutually exclusive, and most researchers recognize a "combined strategy," as introduced by the Melbourne group (Iyer and Mee [26]), that combines the unifocalization and rehabilitation pathways (Fig 1). Most teams have a preferred strategy, although a few groups adopted a mixed management of their patients [27–30].

The Stanford and Birmingham approach has been to incorporate all significant MAPCAs into a policy of early and complete unifocalization—although always utilizing as much of the NPA system as possible. The Melbourne approach has been influenced by the review of the entire historic cohort (n = 82) [31] that found disappointing evolution of unifocalized MAPCAs after a median follow-up of 14.2 years (the longest reported). The consequence was a radical change of the local strategy toward the rehabilitation pathway, focusing on the NPA and avoiding the incorporation of MAPCAs where possible.

The main outcomes are reported in Table 1, which includes 12 studies and their related publications when present. The PA/VSD/MAPCAs were considered repaired when the VSD was closed. One of the key findings from these large series has been the recognition of the heterogeneity in pulmonary blood supply: most patients have a mixed blood supply from a NPA (intrapericardial) system—which is very variable in size and extent—and from a variable number of MAPCAs. The degree to which these two systems overlap is also very

variable, with some areas of the lung having a "dual supply" (ie, fed by both MAPCAs and NPAs) whereas others are supplied exclusively by MAPCAs or exclusively by NPAs. There is a group of 15% to 20% of patients who have complete absence of any NPA [23, 32].

Unifocalization

Unifocalization aims at promoting the growth of MAPCAs without rehabilitating the NPAs. The concept was introduced in 1981 by Haworth and colleagues [18], who suggested to make the "multifocal blood supply unifocal." Unifocalization of MAPCAs was successfully performed only later in the 1980s. The technique consists in anastomosing ipsilateral MAPCAs to each other directly, through patches or through a conduit, and incorporating the ipsilateral native or central pulmonary artery if present (Fig 2A). In a staged procedure, MAPCAs can be unifocalized to a systemic to pulmonary artery shunt (SPS). The procedure can be performed through (postero) lateral thoracotomy or a midline sternotomy. Specific respiratory complications of unifocalization, including airway ischemia [33] and pulmonary reperfusion injury [34], have been reported.

ONE-STAGE UNIFOCALIZATION. The Stanford group (Hanley and colleagues) pioneered the midline unifocalization with repair in a single stage. The first patients underwent this pathway in 1992 [24], after successful case reports by other researchers [35, 36]. In their last publication with 458 patients (the largest cohort to our knowledge), Bauser-Heaton and colleagues [25] reported a repair rate of 88% at a median age of 8.6 months when this strategy was preferentially used for patients. This study showed the highest repair rate and the lowest age at repair of all other experiences combined. Early and late mortality rates were 3.5% and 8.9% respectively. Median right ventricle to left ventricle pressure ratio (pRV/pLV) was 0.40, the lowest reported, expressed as pulmonary artery to aorta pressure ratio (pPA/pAo). However, the median time of measurement of this ratio after repair was uncertain. Estimated survival was 85% at 5 years.

The Birmingham (UK) team [37] have also promoted the one-stage repair with unifocalization as their preferred strategy, using the midline sternotomy approach where possible—but also advocating combined thoracotomy with sternotomy where necessary to access the MAPCAs. Other groups use unifocalization alongside with another strategy: rehabilitation strategy [27] or combined strategy [28, 29].

STAGED UNIFOCALIZATION. The staged unifocalization advocates separate procedures to achieve ipsilateral unifocalization or to recruit vessels in stages to eventually achieve complete unifocalization. That may be helpful when specific vessels are difficult to access through a single approach or if the quality of vessels is poor and a degree of rehabilitation and growth is also required to achieve repair, as will be discussed. An example of this approach is described by Ishibashi and colleagues [38] obtaining an 80% repair rate at a mean age of 8.1 years. Early and late mortality rates were 7% and 15.9%, respectively. This strategy of always using a staged approach is now less popular and no longer followed by many teams [39, 40].

Rehabilitation

Rehabilitation was historically the first strategy applied in PA/VSD/MAPCAs (ie, from the mid 1970s) as an overarching first operation [41–43]. The goal is to promote the growth of hypoplastic NPAs by surgically (or interventionally) generating antegrade blood flow, without intervention on MAPCAs, before reassessing for definitive repair. Rome and colleagues [44] demonstrated in 1993 the feasibility and safety of a rehabilitation strategy only in PA/VSD with hypoplastic pulmonary arteries (excluding patients with absent pulmonary arteries). The concept recognizes the key fact that the NPAs are often hypoplastic in this condition, yet have potentially excellent distribution into the lung parenchyma. Generating good antegrade flow into these native vessels can be uniquely effective in developing growth of the vessels and opening up their distribution.

The recent experience at the Royal Children's Hospital Melbourne [45] showed a repair rate of 82% when the cohort mostly (89%) followed this strategy. There was no early death and 3 (10%) late deaths among 33 patients. After a median follow-up of 4.5 years, the VSD was closed in 73% of patients at a median age of 1.7 years (after a mean of 2 procedures) when patients exclusively underwent the rehabilitation pathway. The median pRV/pLV ratio was 0.64 at a median of 22 months after repair. The concept of rehabilitation has equally been applied to individual MAPCAs where the distribution of the vessel is good but has been deprived of flow (owing to origin stenosis or tortuosity of the vessel, which is often a progressive process). Mobilization of such vessels with or without patch enlargement and then connection to the aorta with a systemic shunt can also be effective in promoting growth. This procedure can be combined with ipsilateral unifocalization, so that the concepts of rehabilitation and unifocalization overlap.

The rehabilitation strategy can be divided into subgroups, according to the first palliation procedure: systemic to pulmonary artery shunt, insertion of the main pulmonary artery in the aorta, or right ventricle to pulmonary artery (RV-PA) connection.

SYSTEMIC TO PULMONARY ARTERY SHUNT. Central shunt (Fig 2B) using a Gore-Tex vascular graft (W. L. Gore & Assoc, Flagstaff, AZ) is the preferred choice in Melbourne, as described by Gates and colleagues [46]. The insertion of a modified Blalock-Taussig shunt represents another option.

INSERTION OF MAIN PA IN AORTA. Iyer and Mee [26] and others [28, 29, 31, 47, 48] originally described an end-to-side anastomosis of the main pulmonary artery to the ascending aorta, the so-called Melbourne shunt (Fig 2C). This type of shunt and strategy was used in reports of selected patients with present native and diminutive central pulmonary arteries, in other words, PA/VSD type

Table 1. Overview of Main Studies on Pulmonary Atresia With Ventricular Septal Defect and Major Aortopulmonary Collateral Arteries Since 2000

First Author [Reference], Location	Year of Publication	Related Previous Publication	Years of Study	Number of Patients	22q11 Deletion Prevalence (%)	Absent CPA (%)	Age at First Surgery (range)	Strategy Preferred	Strategy Subgroup Preferred	One-Stage Repair (% [n/N])
1. Reddy [23], Stanford, CA	2000	Reddy, 1995 [24]	1992–1998	85	14[a]	16	7 m (10 d–37 y)	Unifocalization	One-stage repair	65.9 (56/85)
2. Gupta [48], Los Angeles, CA	2003	Permut, 1994 [66]	1983–2000	104	…	21	1 w (3 d–22 y)	Combined	Melbourne shunt	N/A
3. d'Udekem [31], Melbourne, AU	2005	Iyer, 1991 [26]	1979–1995	82	…	…	1.4 y (7 d–34 y)	Combined	Melbourne shunt	N/A
4. Ishibashi [38], Tokyo, Japan	2007	Sawatari, 1989 [63]	1982–2006	113	26	15	6.3 y (1.1 m–33.8 y)	Unifocalization	Staged repair	N/A
5. Song [39], Seoul, Korea	2009	N/A	1988–2006	40	…	42	8.5 m (6 d–16 y)	Unifocalization	Staged repair	N/A
6. Davies [37], Birmingham, UK	2009	Griselli, 2004 [32]	1989–2008	216	…	…	…	Unifocalization	One-stage repair	51.4 (111/216)
7. Zhu [28], Toronto, Canada	2016	Honjo, 2009 [67]	2000–2013	30	…	16	…	Unifocalization	One-stage repair	93.3 (28/30)
				17			…	Combined	Melbourne shunt	N/A
8. Bauser-Heaton [25], Stanford, CA	2017	Reddy, 1995 [24]	2001–2016	458	36[a]	…	4 m (1.3–7.3)	Unifocalization	One-stage repair	63.9 (186/291)
9. Soquet [45], Melbourne, AU	2017	Liava'a, 2012 [68]	2003–2014	33	39	6	3.3 w (0.4–31.9)	Rehabilitation	Central shunt	N/A
10. Babliak [29], Kyiv, Ukraine	2017	N/A	2007–2009	28	53[a]	18	10 m (2–336)	Unifocalization	One-stage repair	71.4 (20/28)
			2010–2014	55	42[a]	18	9.7 m (1–180)	Combined	Melbourne shunt	N/A
11. Jia [30], Guangzhou, China	2017	N/A	2007–2015	28	…	29	25 m (3–288)	Combined	RV-PA connection	N/A
				24		0	49 m (1–274)	Rehabilitation	RV-PA connection	N/A
12. Trezzi [59], Roma, Italy	2017	Carotti, 1998 [69]	1996–2015	95	38	24	1 y (21 d–14.5 y)	Unifocalization	One-stage repair	67.4 (64/95)

[a] Part of the cohort was missing for calculation of the reported rate. [b] Repair rate, ventricular septal defect closed. [c] One-stage repair. [d] Pulmonary artery pressure to aortic pressure (pPA/pAo). [e] After repair.

CPA = central pulmonary arteries; d = days; ellipses = missing information; m = months; N/A = not applicable; pLV = left ventricular pressure; pRV = right ventricular pressure; RV-PA = right ventricle to pulmonary artery; TNPAI = total neopulmonary arterial index; w = weeks; y = years.

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B [49, 50]. The technique has been particularly successful in smaller infants in rehabilitating the NPA system—diminutive-sized central vessels may be more suited to a direct anastomosis as a prosthetic graft can distort or angulate them if they are only 2 mm to 3 mm in size. There is little risk of overcirculation as the vessels are so small that they provide a natural limit on the flow.

RV-PA CONNECTION. The main advantage of this technique is that it sustains diastolic pressure and also delivers predominantly desaturated blood to the lungs (although the VSD is left open, the streaming effect is such that predominantly systemic venous blood will be directed through the conduit) and so achieves more efficient oxygenation than with a systemic shunt. The technique also gives antegrade access to the pulmonary artery tree to perform subsequent interventions such as balloon pulmonary angioplasty. This technique has been promoted by the Birmingham approach [51], and several teams favor this technique as the initial procedure for a rehabilitation strategy [30, 52, 53]. The RV-PA connection can be established in various ways: a transvalvar autologous pericardial patch, a Gore-Tex vascular graft [45, 54], or a homograft or other valved conduits [53]. A valved conduit will reduce the volume load on the ventricle and the use of stiff conduits of fixed size such as the Hancock Dacron conduit (Medtronic, Minneapolis, MN) will maintain predicted flow while preventing the risk of dilation under pressure.

Combined Strategy

Iyer and Mee [26] in Melbourne described a staged approach in 1991, consisting of the promotion

Table 1. (Continued).

Index Used for Decision	Repair Rate[b] (%)	Age at Repair	Early Mortality Rate (%)	Late Mortality Rate (%)	pRV/pLV After Repair	Time of pRV/pLV Measurement	Palliation Rate (%)	Follow-Up	Survival Overall (%)
None	95	7 m (10 d–37 y)	10.6	8.2	0.44[c]	Intraoperative	…	22 m (1 m–69 m)	74 at 4 y
None	56	5.2 y (1–34)	11.5	5	0.55	…	…	10.2 y	83.5 at 10 y
None	65	4 y (3 m–35 y)	8	…	0.62	1.4 years	…	14.2 y (3 m–25 y)	51 at 12 y[e]
None	80	8.1 y (8.3 m–26.7 y)	7	15.9	0.7	Intraoperative	5.3	8.8 y (0.8 m–23.3 y)	69.9 at 20 y
None	42	3 y (4 m–15 y)	3.8	12.5	0.57	Intraoperative	…	54.5 m (13.4 m–205.1 m)	70.5 at 15 y
None	73	…	6	6	…	…	…	2.3 y (0.1 y–6.7 y)	89 at 3 y
None	77	…	4	14	…	…	…	2.2 y (0.02 y–14.1 y)	78.5 at 5 y
	65	…							
None	88	8.6 m (4.9–29)	3.5	8.9	0.40[d]	…	1.9	3 y (0.6 y–7.9 y)	85 at 5 y
None	73	1.7 y (0.2–6.7)	0	10	0.64	22.2 months	10	4.5 y (0.04 y - 8.3 y)	…
Nakata	82	…	10.7	0	…	…	6	7.9 y	92.6 at 9 y
	60	…	0	5.4				3.8 y	
TNPAI	43	…	11.5	13.5	…	…	…		
	62	…						1,145 d (0 d–3451 d)	78 at 5 y
None	67	…	8.4	5.2	0.49	Intraoperative	…	8.5 y (0.01 y–19.9 y)	78 at 15 y

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(rehabilitation) of the NPAs, followed by the unifocalization of NPAs and MAPCAs before repair. Gupta and colleagues [48] reported the largest experience with this strategy (104 consecutive patients) in 2003. As discussed previously, many of the reported series that focus on both unifocalization and on rehabilitation will overlap in this combined approach—often needing two or more procedures before repair can be attempted or achieved.

Overlap Between Strategies

There is likely an overlap between the strategies described that may be obvious only to the experienced reader. It is more than likely that patients with small but not extremely diminutive central pulmonary arteries that are connected to most lung segments would have a preparatory procedure to make them grow in all teams. A team operating under a flagship of unifocalization strategy would still categorize this patient as a success of a unifocalization strategy even though the unifocalization involved both MAPCAs and rehabilitated NPAs at the time of repair. Conversely, a patient who underwent a central shunt soon after birth in a team with a flagship of rehabilitation procedure would be classified as a success of this strategy even though an isolated lobar branch perfused by a single MAPCA was connected to the native pulmonary vessels at the time of repair. This patient would be considered a success of unifocalization by the first team.

Concept of Leaving VSD Open

In cases where the quality or distribution of the pulmonary vasculature is poor, then it may not be possible to

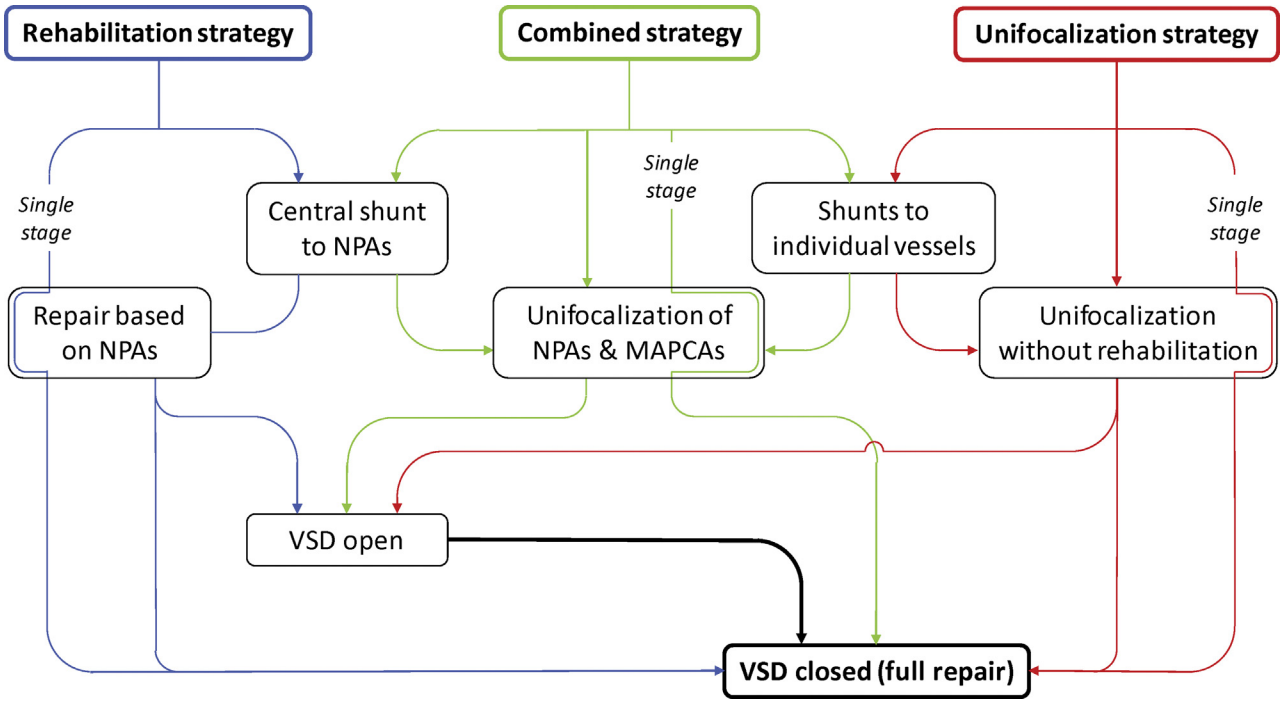

Fig 1. Overview of management strategies for pulmonary atresia with ventricular septal defect (VSD) and major aortopulmonary collateral arteries (MAPCAs). Note: one arrow represents one stage; single-stage repair pathways are represented by a single arrow going through a procedure box before reaching the "VSD closed (full repair)" box. (NPA = native pulmonary artery.)

perform a complete repair (ie, close the VSD and septate the circulation) for risk of suprasystemic RV pressure and RV failure. These decisions are based on the amount of vasculature recruited (minimum 15 of 20 lung segments) or on the intraoperative flow studies. In these situations, there are two options: either the unifocalized vessels are fed by a central shunt, or they can be connected to the heart using an RV-PA conduit that is deliberately restrictive in size. The latter aims to create a situation analogous to a "balanced tetralogy of Fallot" where the restrictive conduit prevents any risk of overcirculation. That has the advantage of sending desaturated blood to the lungs and providing good access for subsequent catheterization—but at the expense of a ventriculotomy. Both approaches have been used successfully, and there is no evidence to suggest one approach is better than the other.

Associated Procedures of PA Enlargement and Interventional Catheterization

All strategies share the necessity of reintervention on pulmonary arteries or MAPCAs by surgery or interventional catheterization procedures. Often hypoplastic before any intervention, pulmonary arteries can show stenosis or hypoplasia in their evolution and may require surgical enlargement with patches or percutaneous dilation and stenting [45]. MAPCAs are also known to stenose or thrombose [15, 16, 31, 36, 39] after unifocalization and can be treated with percutaneous dilation or repeated surgery. In addition, some larger MAPCAs connected to the native pulmonary arteries and causing overcirculation by a dual supply may need to be surgically ligated or coil embolized once antegrade flow has been established [37].

Summary

PATIENTS' CHARACTERISTICS. Studies published since 2000 on PA/VSD/MAPCAs in consecutive series of patients (Table 1) showed a wide range of ages at the time of first surgery (from 3.3 weeks to 6.3 years), depending on the period of treatment and referrals. Of note, the rate of 22q11 microdeletion was reported in approximately half of all cases. The prevalence in recent surgical series was usually 35% to 40%. It has been demonstrated that the anatomy of the pulmonary and systemic-pulmonary vasculature is influenced by 22q11 microdeletion [55, 56] in PA/VSD, generally carrying a negative prognostic value on outcomes [57, 58]. The proportion of patients with absent central pulmonary arteries (PA/VSD type C) varied mostly between 15% and 20%, and rarely exceeded 30% when reported.

STRATEGIES. Unifocalization is currently the most common strategy but the superiority of one strategy over another would be hard to assess at the time of this review. Several teams with extensive published experience have advocated for the one-stage repair [25, 37, 59]. Although earlier referral and earlier unifocalization are associated with the best outcomes, there remains a group of patients at the worst end of the spectrum (10% to 15% of the entire PA/VSD/MAPCAs population) who present with profound cyanosis and poorly developed pulmonary vasculature.

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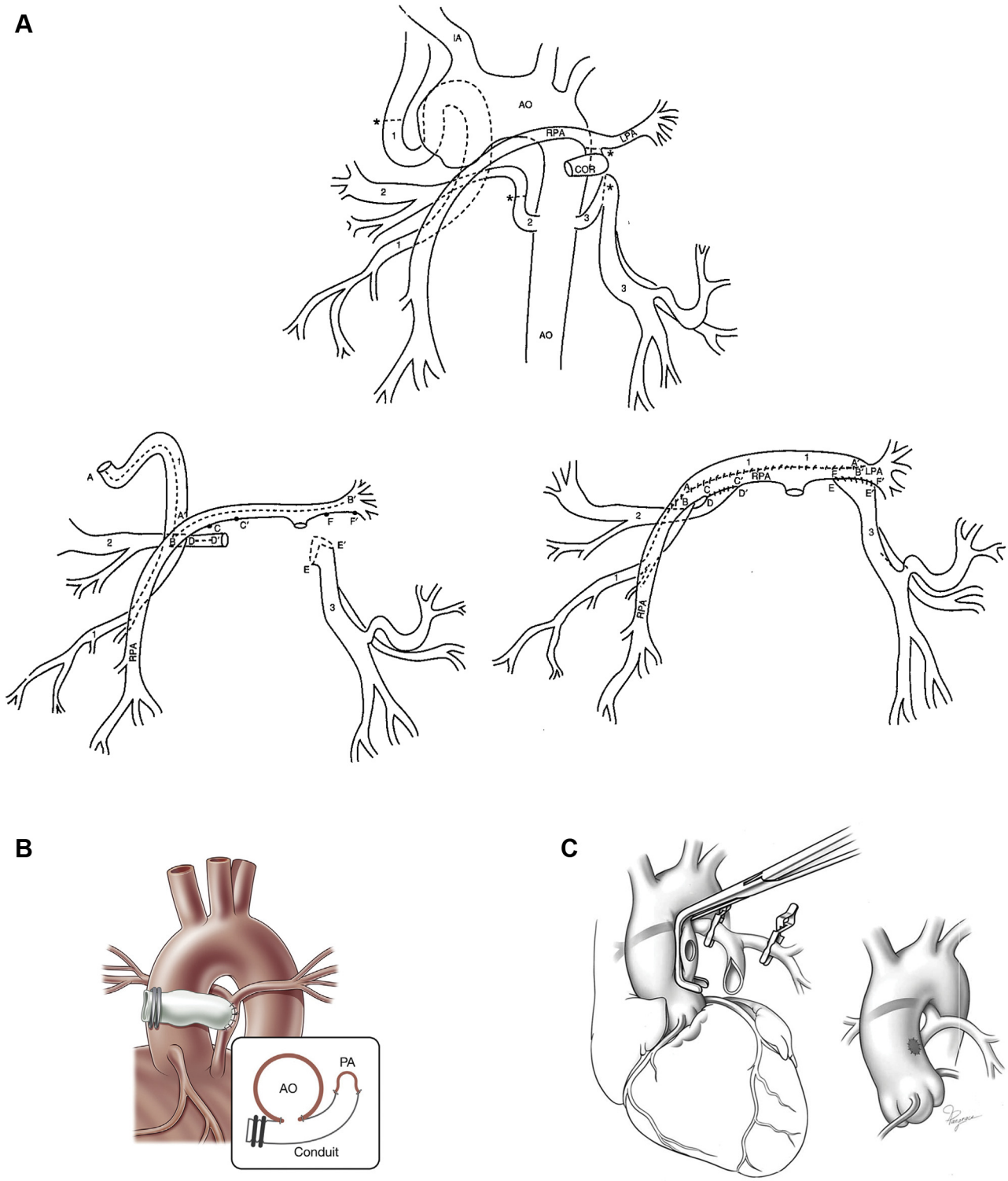

Fig 2. Examples of unifocalization and rehabilitation procedures. (A) Unifocalization of bilateral major aortopulmonary collateral arteries (MAPCAs) directly to the native pulmonary arteries. (Ao = aorta; COR = coronary collateral; IA = innominate artery; LPA = left pulmonary artery; RPA = right pulmonary artery.) (Reproduced from Reddy and colleagues [24] with permission from The American Association for Thoracic Surgery.) (B) Central shunt with a Gore-Tex vascular graft. (Ao = aorta; PA = pulmonary artery.) (Reproduced from Soquet and colleagues [45] with permission from The Society of Thoracic Surgeons.) (C) Central aorta to pulmonary shunt (Melbourne shunt). (Reproduced from Mumtaz and colleagues [49] with permission from The Society of Thoracic Surgeons.)

Single-stage unifocalization can rarely be achieved in these patients, and palliative shunts, ipsilateral unifocalizations, or Melbourne shunt are often all that can be offered initially for this group.

The Stanford group performed repair in 88% of patients at 8.6 months, with a very low early mortality rate (3.5%) [25]. The Birmingham approach reported 2.8% early mortality among 249 patients undergoing unifocalization and repair [51], with a further 22 patients (8.5%) remaining palliated with shunts. The Melbourne study achieved repair in 82% of patients with no operative mortality at an age of 1.7 years, which is early considering that this strategy is staged [45]. With a combined staged strategy involving 60 patients, Babliak and colleagues [29] had a repair rate of 60% with no early mortality.

There is no doubt that NPAs provide the best platform on which to base ultimate repair and that patients who have recruitable (or rehabilitatable) NPAs will have the best long-term results. Nevertheless, there are cases where there is complete absence of NPAs—yet unifocalization and repair has been achieved using MAPCAs exclusively. Furthermore, many cases will have a mixed pulmonary blood supply coming from both NPAs and from MAPCAs, and the results from Stanford and Birmingham would suggest that unifocalization of both components yields excellent results.

Different indexes have been suggested to estimate the size and cross-sectional area of the pulmonary or neopulmonary arborization [60–62]. Although those indexes have been repeatedly reported [28–30,38,39], the recent publications listed in Table 1 interestingly reveal that they have been very rarely involved in the decision-making process [29, 30]. Most groups decided on the progression of their patients according to a suggestive estimation of the size of the pulmonary tree measured by the percentage of segments of the lung perfused (images of angiography or computed tomography) [37, 45] or according to an intraoperative flow study [23, 25, 28, 59].

OUTCOMES. Depending on institutions and strategies, the repair rate varies between 42% and 95%. The age at repair was missing in several of the reported studies. Early mortality for patients with PA/VSD/MAPCAs was acceptable, with a rate of less than 11.5% all institutions, strategies, and procedures combined, and inhospital mortality of less than 5% in the larger series. After repair, pRV/pLV was not always measured, and apart from intraoperative measurements, the time between repair and measurement of the ratio was specified in only two studies (by the Melbourne group). The overall survival rates were mostly between 78% and 85% at a range varying from 3 years to 20 years after the first surgery.

In all series, there is a small number of patients who still cannot be repaired owing to the poor development of NPAs or unifocalized MAPCAs, regardless of the strategy. This category of patients is unlikely to undergo a septation and is left palliated, cyanotic but alive. As seen in Table 1, these data were rarely mentioned. When not available but clearly stated, the proportion of palliated patients was calculated according to the method described in Figure 3 [25, 29] and varied from 1.6% to 10%. The category of patients "awaiting repair" is not included in the calculation process because of the uncertain fate (repair, death, or palliation), even when repair is likely.

Comment

This review offers an updated comparison of the main studies on PA/VSD/MAPCAs published since 2000. Of note, all publications were retrospective. We have demonstrated that the surgical management of PA/VSD/MAPCAs has evolved into three main strategies: unifocalization, rehabilitation, and a combined strategy. This review also shows a great heterogeneity in patients treated and deficiencies in data reporting.

Unifocalization, Rehabilitation, and Combined Strategy

The strategy described by Iyer and Mee was named "staged repair" by the original researchers and others [47, 48], and was classified as being a part of the unifocalization group. After having described the unifocalization and rehabilitation strategies earlier in this review, it seems obvious that the term "staged repair" can be confusing for any reader because it can also refer to a subgroup of the unifocalization strategy [38, 63] as well as to rehabilitation because of the inevitable staged nature of the latter.

Common Themes

The Stanford team highlighted that some neonates require early repair when presenting in heart failure [64]. Heart failure, especially early in life, implies well-developed pulmonary vasculature and suitability for early biventricular repair. In many instances, these patients have a limited number of collateral arteries, and single-stage repair with unifocalization is feasible with excellent results. All teams seem to have accepted this strategy.

Also, when small central pulmonary arteries are present and seem to be distributed to most of both lungs, most teams will grow these pulmonary arteries by either a central shunt, a Melbourne shunt, or restoration of the RV-PA continuity. Although it is not clear from publications by teams who have adopted unifocalization strategies, because the details of the operative procedures are often unreported, this practice is currently common.

A technical aspect that has become clear is that the unifocalized vessels should be dissected from the aorta and mobilized as distally as possible because the collateral segment of these vessels can considerably remodel and become stenotic. This dissection is by far more easily done in a virgin field, and all efforts should be made for that dissection to be performed only once. MAPCAs are frequently located very posteriorly in the mediastinum, and division of their origin with extensive mobilization can help bring the vessels further forward and avoid

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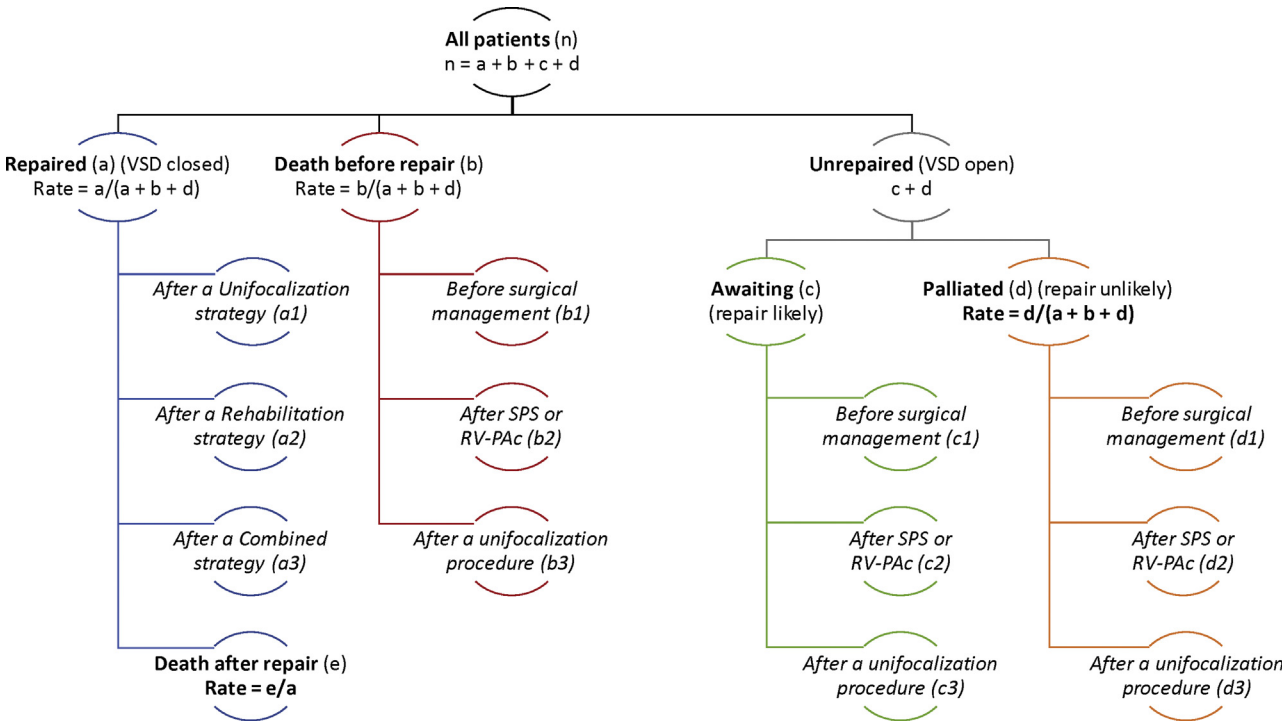

Fig 3. Recommended presentation of outcomes regardless of strategy. (RV-PAc = right ventricle to pulmonary artery connection; SPS = systemic to pulmonary shunt; VSD = ventricular septal defect.)

compression on the neighboring airways. Also, identification of the vessels within the fissures of the lung can provide better access, requiring confident and extensive mobilization of the lungs that is not a feature of most cardiac surgeries and which demands considerable experience and confidence with the anatomy. Detailed three-dimensional imaging with computed tomography and magnetic resonance imaging is essential to define the relationship of the vessels with the main airways and esophagus.

INVESTIGATIONS. An extensive imaging study is necessary at presentation of all patients. Injections of each MAPCA in angiographic studies are essential to define pulmonary blood supply and to establish areas supplied solely by MAPCAs and those with dual supply. Pulmonary vein wedge injections may reveal "orphaned" vessels that had lost their initial blood supply but fill retrogradely and can be recruited. As an alternative, computed tomography scan or magnetic resonance imaging can be performed before surgery and have the advantage over angiographic studies to be able to define the relationship of the vessels to the airways and esophagus.

PALLIATION. Whether some patients are better left palliated at least in the first years of life remains an open question. Patients at the most extreme end of this spectrum of the disease may be those at higher risk of early mortality, such as infants with absent or diminutive central pulmonary arteries and multiple collaterals with no connection to any intrapulmonary vessel and distal near-normal arborization. These patients may survive many years with a good quality of life. Some investigators report that late unifocalization of some of these patients after several years of palliation can be quite successful, alleviating the challenges of performing this surgery in smaller infants [31].

WHEN UNIFOCALIZING, SHOULD WE UNIFOCALIZE EVERYTHING?. Most teams will proceed with unifocalization in a varying proportion of patients. Even those prone to follow a strategy of rehabilitation will unifocalize neonates in heart failure and patients failing the rehabilitation strategy. When faced with diminutive collateral vessels, the question arises as to whether they are best left alone or unifocalized. An area of debate remains as to whether a staged approach to such vessels may be better or whether there is a critical size or area of distribution at which recruitment has no long-term benefit.

Long-Term Outcomes

Aiming to achieve septation wherever possible is a laudable approach but risks leaving some patients with a hypertensive RV and at risk of developing RV dysfunction and failure. Patients with pulmonary vasculature at the poorer end of the spectrum may be better managed by leaving the VSD open and utilizing shunts or limiting RV-PA conduits as long-term palliation. This approach may give very good long-term quality of life in selected patients. Finding the

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threshold at which each strategy meets the best long-term outcome for these patients is a further question to be answered through better classification of the spectrum of disease.

Moreover, as survival has nowadays become acceptable, we would be able to compare the various strategies, not only in terms of combined morbidity including number of surgeries and repeated operations or interventional catheterization procedures, but also in terms of functional capacity and quality of life.

Recommendations for Authors

An important observation extracted from this review is the variability in the reporting of data. Without greater standardization of reporting results, it will be difficult to ascertain the superiority of techniques and approaches [65]. Given our analyses, we recommend that all the following data, listed in Table 1, should be reported: prevalence of 22q11 microdeletion, proportion of patients with absent central pulmonary arteries (PA/VSD type C), pre-repair procedures and timing, age at repair, post-repair pRV/pLV ratio and pPA/pLV ratio and their time of measurement, and proportion of patients left palliated indefinitely, calculated according to the described method (Fig 3).

Attention should also be paid to the anatomic characterization of central pulmonary arteries (presence, confluence, size) and MAPCAs (presence and number, size, origin, course and supplied pulmonary segments, connection with the native pulmonary arteries—dual supply).

Most reports today are alluding to the general philosophy of repair followed by each center, but insufficient data are provided to identify the best strategy and procedures in the various subset of patients composing this complex condition.

We propose that every patient be given an individualized code that represents their exact anatomy and a second code that describes the procedures (see Table 2 for definition of MAPCAs and proposed standard format for recording current patient status): (1) MAPCA coding: for each lung, the number of MAPCAs with notation as to whether they are sole supply or dual supply; size is indicated by number of segments supplied. (2) Native PA coding: complete absence as a separate code; if present, then size and distribution to each lung (size: diminutive, small, moderate). (3) Procedure: one-stage complete repair. (4) One-stage unifocalization (to shunt or to RV-PA conduit). (5) Ipsilateral unifocalization or shunt procedure to MAPCA/PA only.

Staged approaches would then list the subsequent procedures with a similar code: second shunt, complete repair, unifocalization only, and so forth. Therefore, a patient could be described as having three MAPCAs: one with dual supply to left lung; one with sole supply to left lung (three segments); and one with dual supply to right lung. The NPAs were present but small to the left and moderate to the right. This patient might have undergone procedure 1, unifocalization with RV-PA conduit (VSD left open) of native PAs plus recruitment of one MAPCA and ligation of two MAPCAs; or procedure 2, complete repair.

Conclusion

The surgical management of PA/VSD/MAPCAs has evolved into three primary surgical strategies. Outcomes are excellent with both the rehabilitation strategy and the unifocalization strategy (more than 80% achieving full septation). There remains some debate over the value of always recruiting all MAPCAs, but the best results are achieved when MAPCAS are recruited in the absence of dual supply or poorly developed native pulmonary arteries. Investigators should be encouraged to

REVIEW

Table 2. Proposed Definition of MAPCAs and Standard Format for Recording Current Patient Status

MAPCA Definition	Example
Each vessel coded by	MAPCA #1, right subclavian artery, RUL, three segments, sole supply
Origin ± bifurcation[a]	MAPCA #2
Position	#2a, descending aorta, RML, two segments, dual supply (with RPA)
Number of segments supplied	#2b, descending aorta, LUL, two segments, sole supply
Sole supply or part of dually supplied segment	MAPCA #3, and so forth
Standard format for recording current patient status	
Shunt procedures to individual vessels	
Can be subclassified into those with subsequent unifocalization anticipated and those seen as final destination	
Shunt or RV-PA connection to native PAs	
Can be subclassified as those with subsequent unifocalization anticipated and those seen as final destination	
Unifocalized but ventricular septal defect left open	
Can be further subclassified by whether subsequent full repair is anticipated	
Can also be subclassified by whether unifocalization was achieved in single stage or after previous shunt	
Unifocalized and ventricular septal defect closed (ie, full repair)	

[a] One major aortopulmonary collateral artery (MAPCA) that bifurcates would be coded #Xa and #Xb.

LUL = left upper lobe; PA = pulmonary artery; RML = right middle lobe; RPA = right pulmonary artery; RUL = right upper lobe; RV = right ventricle.

standardize the reporting of their data to better elucidate optimal strategies and procedures.

Yves d'Udekem is a NHMRC Clinical Practitioner Fellow (1082186). The Victorian Government's Operational Infrastructure Support Program supported this research project.

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REVIEW

September 8, 2021

Scott Manaker, MD
AMA/RVS Update PE Subcommittee
American Medical Association
330 N. Wabash Avenue
Chicago, IL 60611

Re: Tab 8 Pulmonary Angiography

Dear Dr. Manaker:

Tab 8 on the October 2021 RUC agenda addresses four new codes and six existing codes, which describe various pulmonary angiography services. All ten of these ZZZ services will be provided exclusively in the facility setting. As such, the Society for Cardiovascular Angiography and Interventions and the American College of Cardiology recommend no direct practice expense inputs for Tab 8.

Thank you for your consideration of this information as you prepare for the upcoming meeting. Please contact James Vavricek at jvavricek@acc.org if you have any questions.

Sincerely,

Edward Toggart, MD
SCAI RUC Advisor

Richard Wright, MD
ACC RUC Advisor

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2021

Quantitative Pupillometry Services – Tab 9

The CPT Editorial Panel approved a new Category I CPT code to replace the sunset Category III CPT code 0341T *Quantitative pupillometry with interpretation and report, unilateral or bilateral* and 92499 *Unlisted ophthalmological service or procedure* for reporting this service. Code 0341T was sunset within the *CPT 2020* code set and instruction was included in a parenthetical cross-reference directing use of unlisted code 92499 when quantitative pupillometry was provided. CPT code 95919 was surveyed for the October 2021 RUC meeting.

Code 95919 identifies unilateral or bilateral quantitative pupillometry. This service provides non-invasive measurements of autonomic nervous system function that inform objective quantification of pupillary response to light. The holistic interpretation of this collected information can be effectively applied to many disorders in adults, children, and infants; a physician can ascertain details of sympathetic and parasympathetic function based on the interpretation and documentation of this service. The specialty societies noted that while the data is collected by a technician, the data is analyzed and assessed by a physician or another qualified health care (QHC) professional.

95919 *Quantitative pupillometry with physician or qualified health care professional interpretation and report, unilateral or bilateral*
The RUC reviewed the survey results from 36 physicians and recommends the survey 25th percentile work RVU of 0.25 for CPT code 95919. The RUC recommends 1 minute of pre-service evaluation time, 5 minutes of intra-service time and 1 minute of immediate post-service time. The specialties noted that the 5 minutes of intra-service time includes time to conduct an extensive review and intrepretation of the collected data; the physician will review individual wave forms, compare each data point to published normative measures by age, check for asymmetric or unique patterns, check for consistency across sympathetic tones, and complete a report that draws in other correlations and intervention recommendations. Therefore, the RUC determined that 5 minutes of intra-service time is appropriate for this comprehensive review and reporting.

The RUC compared the surveyed code to the top key reference service (KRS) 92081 *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)* (work RVU = 0.30 and 10 minutes total time) and determined that the surveyed code RVU is valued appropriately lower, specifically in terms of the amount of time allocated for intra-service review. The RUC compared the surveyed code to the second top KRS 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU = 0.50 and 13 minutes total time) determined that the surveyed code requires less physician work and total time than CPT code 92083, and thus is valued appropriately lower at approximately half the work RVU value.

CPT code 92202 *Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) withinterpretation and report, unilateral or bilateral* (work RVU= 0.26, 5 minutes of intra-service time and 7 minutes total time) was identified as

an optimal comparison to CPT code 95919 due to identical intra-service time and total time. Additionally, the physician work required to perform this service is comparable, and therefore should be valued similarly to maintain relativity. For additional support, the RUC referenced CPT code 72190 *Radiologic examination, pelvis; complete, minimum of 3 views* (work RVU= 0.25, 5 minutes of intra-service time, and 7 minutes of total time) requires the same amount of time and has an identical work RVU and thus should be valued similarly.**The RUC recommends a work RVU of 0.25 for CPT code 95919.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

New Technology/New Service
The RUC recommends that CPT code 95919 be placed on the New Technology list and be re-reviewed by the RUC in three years to ensure correct valuation and utilization assumptions.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Medicine **Neurology and Neuromuscular Procedures** **Autonomic Function Tests** *The purpose of autonomic nervous system function testing is to determine the presence of autonomic dysfunction, the site of autonomic dysfunction, and the various autonomic subsystems that may be disordered. …* *Code 95924 should be reported only when both the parasympathetic function and the adrenergic function are tested together with the use of a tilt table.* *~~(To report autonomic function testing that does not include beat-to-beat recording or for testing without use of a tilt table, use 95943)~~*				
●95919	Q1	Quantitative pupillometry with physician or qualified health care professional interpretation and report, unilateral or bilateral	XXX	0.25
0338T		*Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision*		

and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiograph when performed; unilateral

0339T bilateral

(Do not report 0338T, 0339T in conjunction with 36251, 36252, 36253, 36254)

(0341T has been deleted)

(For quantitative pupillometry with interpretation and report, unilateral or bilateral, use ~~92499~~95919

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:95919 Tracking Number Q1 Original Specialty Recommended RVU: **0.25**
Presented Recommended RVU: **0.25**
Global Period: XXX Current Work RVU: **N/A** RUC Recommended RVU: **0.25**

CPT Descriptor: Quantitative pupillometry with physician or qualified health care professional interpretation and report, unilateral or bilateral

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 14-year-old boy playing football got tackled and developed a concussion. He now requires a comprehensive neurologic examination to assess for vestibular, balance, and vision problems. To assess the concussion severity, he requires cranial imaging tests such as magnetic resonance imaging or computerized tomography, along with quantitative pupillometry to assess pupillary response to light as an early indicator of increased intracranial pressure.

Percentage of Survey Respondents who found Vignette to be Typical: 47%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the referring physician's request. Enter an order into the electronic health record. Describe the test and its purpose to the patient and/or family.

Description of Intra-Service Work: Physician/QHP reviews the measurements and waveforms from both right and left eyes in the context of the patient condition and then compares them to published normative values by age as well as to prior pupillometry measurements in the same patient.

Description of Post-Service Work: Enter results into the electronic health record. Send a report to the referring physician.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	David Glasser, MD; Steven Krug, MD; Debra Weese-Mayer, MD					
Specialty Society(ies):	American Academy of Ophthalmology (AAO); American Academy of Pediatrics (AAP)					
CPT Code:	95919					
Sample Size:	2766	**Resp N:**	36			
Description of Sample:	AAO: Random sample of AAO neuro-ophthalmology members and North American Neuro-Ophthalmology Society (NANOS) members AAP: Random sample of members from the following AAP Sections: Ophthalmology, Neurology, Emergency Medicine					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	18.00	500.00
Survey RVW:	0.10	0.25	**0.30**	0.46	1.00
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	3.00	**5.00**	11.00	30.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	95919	**Recommended Physician Work RVU: 0.25**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**5.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**1.00**	**0.00**	**1.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? Yes

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92081	XXX	0.30	**RUC Time**

CPT Descriptor Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
92083	XXX	0.50	**RUC Time**

CPT Descriptor Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
72081	XXX	0.26	**RUC Time**	9,755

CPT Descriptor 1 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74019	XXX	0.23	**RUC Time**	429,437

CPT Descriptor 2 Radiologic examination, abdomen; 2 views

Other Reference CPT Code	Global	Work RVU	Time Source
72190	XXX	0.25	**RUC Time**

CPT Descriptor Radiologic examination, pelvis; complete, minimum of 3 views

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 15 **% of respondents:** 41.6 **%**

Number of respondents who choose 2nd Key Reference Code: 8 **% of respondents:** 22.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 95919	Top Key Reference CPT Code: 92081	2nd Key Reference CPT Code: **92083**
Median Pre-Service Time	1.00	3.00	3.00
Median Intra-Service Time	5.00	7.00	10.00
Median Immediate Post-service Time	1.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**7.00**	**10.00**	**13.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	7%	53%	33%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	53%	34%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	67%	26%
Physical effort required	0%	93%	7%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	47%	46%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	38%	50%	12%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	12%	75%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	38%	62%
Physical effort required	0%	63%	37%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	38%	62%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

The CPT Editorial Panel approved a new Category I CPT code (95919 *Quantitative pupillometry with physician or qualified health care professional interpretation and report, unilateral or bilateral*) to replace the sunset Category III CPT code 0341T (*Quantitative pupillometry with interpretation and report, unilateral or bilateral*) and 92499 (*Unlisted ophthalmological service or procedure*) for reporting this service. Code 0341T was sunset within the *CPT 2020* code set

and instruction was included in a parenthetical cross-reference directing use of an unlisted code (92499) when quantitative pupillometry was provided.

Code 95919 identifies unilateral or bilateral quantitative pupillometry. Pupillometry provides non-invasive measurements of autonomic nervous system function which allows for objective documentation of pupillometry-specific autonomic deficit in a variety of disorders as well as objective measurement of pupillary response to light. No current method outside of quantitative pupillometry exists to provide such information in this manner (non-invasive, objective, accurate). With careful consideration of the multiple factors involved in the pupillary response to light, pupillometry can be effectively applied to many disorders in adults, children, and infants to ascertain details of sympathetic and parasympathetic function and simultaneously objectively document the pupillary response to light. Thus, pupillometry provides a new clinical application with an existing device. Pupillometry data is typically acquired by a technician and the data is analyzed by a physician or other qualified health care professional.

RUC Survey Results

The American Academy of Ophthalmology (AAO) and the American Academy of Pediatrics (AAP) surveyed 2,766 members, receiving 36 completed responses. AAO surveyed a random sample of AAO ophthalmology members and North American Neuro-Ophthalmology Society (NANOS) members, while AAP surveyed a random sample of members from its Sections on Ophthalmology, Neurology, Emergency Medicine.

The first Key Reference Service (KRS) (**92081** *Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (eg, tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)*) (0.30 wRVU; 3/7/0/10) was selected by 15 (42%) of respondents, while the second KRS (**92083** *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)*) (0.50 wRVU; 3/10/0/13) was selected by 8 (22%) of respondents.

Given the low percentages of respondents who selected either of the Key Reference Services, the fact that both 92081 and 92083 have longer intraservice times (7 minutes and 10 minutes, respectively) than 95919 (survey median intraservice time of 5 minutes), and respondents' ranking of intensity/complexity measures for 95919 (ie, identical to 92081 but higher than 92083), we are not basing our recommendations entirely on either of the Key Reference Services.

Time Recommendations: 1/5/1/7

While our survey median times for pre-service, intraservice, and post-service were each 5 minutes, we are recommending **1 minute pre-service, 5 minutes intraservice, and 1 minute post-service**. We are recommending lower pre- and post-service times to account for the fact that pupillometry is typically performed in conjunction with an Evaluation and Management (E/M) service.

Work Relative Value Unit Recommendation: 0.25 wRVU

We are recommending the survey 25th percentile wRVU of **0.25**, which is half that of the second KRS 92083, which has twice as long an intraservice time.

There are several other RUC-reviewed services that have comparable times and work RVUs:

Code	Descriptor	Global	Work RVU	Pre-Time	Intra-Time	Post-Time	Total Time
74019	Radiologic examination, abdomen; 2 views	XXX	0.23	1	4	1	6
72190	Radiologic examination, pelvis; complete, minimum of 3 views	XXX	0.25	1	5	1	7
95919	Quantitative pupillometry with physician or qualified health care professional interpretation and	XXX	0.25	1	5	1	7

	report, unilateral or bilateral						
92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral	XXX	0.26	1	5	1	7
72081	Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view	XXX	0.26	1	5	1	7

These examples illustrate that the recommended wRVU and times for code 95919 are comparable to services of other specialties in the Medicare Physician Fee Schedule.

The recommended work value of 0.25 RVU is supported by a direct crosswalk to code 72190, *Radiologic examination, pelvis; complete, minimum of 3 views*, last reviewed by the RUC in 2019 and with an identical work value and times.

The Intraservice Work Per Unit of Time (IWPUT) associated with our recommendations (0.041) is minimally greater than that of the first KRS (92081; 0.033). Although comparing IWPUTs between codes with short intraservice times is unreliable, this is consistent with respondents indicating that pupillometry is equally intense/complex as 92081.

We recommend a work value of 0.25 RVU for code 95919 with times of 1/5/1.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☒ Other reason (please explain) Pupillometry is typically provided with a same day E/M service

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

CPT	wRVUs	Global Period	Pre	Intra	Post	Total	Visit Total wRVUs	Visit Total Time
95919	0.25	XXX	1	5	1	7	1.55	37
99213	1.30	XXX	5	20	5	30		

95919	0.25	XXX	1	5	1	7	1.64	47
99232	1.39	XXX	10	20	10	40		

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) Category III CPT Code 0341T (2015-2020) and 92499 (Unlisted ophthalmological service or procedure; 2019 Medicare Frequency = 7,015)

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Pediatrics How often? Sometimes

Specialty Ophthalmology How often? Sometimes

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 7500
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on extrapolation from 2019 Medicare Frequency for 92499 (7,015)

Specialty Pediatrics Frequency 3750 Percentage 50.00 %

Specialty Ophthalmology Frequency 3750 Percentage 50.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 5,000
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimate based on 2019 Medicare Frequency for 92499 (7,015)

Specialty Pediatrics Frequency 250 Percentage 5.00 %

Specialty Ophthalmology Frequency 4750 Percentage 95.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Tests

BETOS Sub-classification:
Other tests

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 92136

SS Rec Summary

ISSUE: Quantitative Pupillometry Services

TAB: 9

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	92081	XXX	Visual field examination, unilateral or bilateral, with	Apr-10	15	0.033	0.030			0.30			10	3					7								
2nd REF	92083	XXX	Visual field examination, unilateral or bilateral, with	Apr-12	8	0.043	0.038			0.50			13	3					10								
CURRENT													0														
AAP	95919	XXX	Quantitative pupillometry with		21	0.015	0.020	0.10	0.13	0.30	0.45	1.00	15	5			1	3	5	10	30	5	0	0	1	17	200
AAO	95919	XXX	Quantitative pupillometry with		10	-0.001	0.016	0.11	0.30	0.31	0.39	0.51	19	6			2	4	5	15	30	8	0	0	1	39	500
NANOS	95919	XXX	Quantitative pupillometry with		5	0.020	0.021	0.15	0.25	0.30	0.50	0.75	14	4			3	4	5	10	10	5	0	0	1	10	20
SVY	95919	XXX	Quantitative pupillometry with physician or qualified health		36	0.015	0.020	0.10	0.25	0.30	0.46	1.00	15	5			1	3	5	11	30	5	0	0	1	18	500
REF	72190	XXX	Radiologic examination, pelvis; complete, minimum of 3 views	Jan-19	54	0.041	0.036			0.25			7	1					5			1					
REC	95919	XXX	Quantitative pupillometry with physician or qualified health			0.041	0.036			0.25			7	1					5			1					

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 95919**
SPECIALTY SOCIETY(IES): AAO, AAP
PRESENTER(S): David Glasser, MD; Ankoor Shah, MD; Steven Krug, MD; Debra Weese-Mayer, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
95919	Quantitative pupillometry with physician or qualified health care professional interpretation and report, unilateral or bilateral	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
95919	A 14-year-old boy playing football got tackled and developed a concussion. He now requires a comprehensive neurologic examination to assess for vestibular, balance, and vision problems. To assess the concussion severity, he requires cranial imaging tests such as magnetic resonance imaging or computerized tomography, along with quantitative pupillometry to assess pupillary response to light as an early indicator of increased intracranial pressure.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   Advisors from AAO, NANOS, and AAP acted as an expert panel, meeting virtually to develop the recommended direct PE inputs.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   PE Reference Code: 92082 *Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination*
   Given the time, patient compliance, and technician work required by quantitative pupillometry, we recommend code 92082 as the PE Reference Code.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see the *Billed Together* tab in the RUC Database)

   Yes, this code will typically be reported with an E/M service.
   Yes, this code will typically be reported with an E/M service in the nonfacility.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see the *Billed Together* tab in the RUC Database)

   While this is a new code, we anticipate that ophthalmology will be one of the dominant providers in the nonfacility and for the global.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A (This is a new code)

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

N/A (This is a new XXX code)

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

N/A

8. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

Reference Code 92082: 5 minutes for "Draw isopters/enter demographics" (Row 41 of April 2012 PE SS) was rolled into CA034 (Document procedure (nonPACS) (eg, mandated reporting, registry logs, EEG file, etc.)).

9. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A (This is a new code)

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

N/A

    b. Service period (includes pre, intra and post):

Eyeglasses or contact lenses are removed and the patient is seated in a dark, quiet room for a minimum of one minute before pupillometry begins. Clinical staff instructs the seated patient to stare straight ahead without blinking or moving the eye. [CA016 2 minutes (standard)] Clinical staff holds the pupillometer up to the patient's right eye, then depresses the measurement button to initiate the recording and the light stimulus. Depending on the age and cooperation of the

patient, this may need to be repeated until a complete recording is made. After a minimum of 1 minute break, the previous step is repeated with the left eye. [CA021 3 minutes]

Clinical staff downloads the pupillometry measurements and the waveforms and prepares a report for physician review and interpretation. [CA028 2 minutes]

Clinical staff wipes down pupillometer with an alcohol swab and places it back in the charger [CA024 1 minute] [Note: CA024 standard is 3 minutes but 95919 is typically reported with an E/M service. While pupillometry is typically performed on the same day as an E/M, these are cleaning activities above and beyond what would be performed during an E/M visit alone.]

==========

Total Service Period Clinical Staff Time (CST) = 8 minutes

We included the standard PE clinical staff time survey question in our Physician/QHP work survey, with the following results:

Low	1 minute
25th	3 minutes
Median	6 minutes
Mean	9.27 minutes
75th	12 minutes
High	40 minutes

N = 33 (AAP = 19; AAO = 9; NANOS = 5)

While our recommended CST time (8 minutes) is higher than the survey median (6 minutes), we believe that survey respondents considered only the CST required for the pupillometry service -- and not the CST required for cleaning or downloading images.

c. Post-service period:

N/A

11. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

Clinical staff holds the pupillometer up to the patient's right eye, then depresses the measurement button to initiate the recording and the light stimulus. Depending on the age and cooperation of the patient, this may need to be repeated until a complete recording is made. After a minimum of 1 minute break, the previous step is repeated with the left eye. Depending on the age and cooperation of the patient, this may need to be repeated until a complete recording is made. [CA021 3 minutes]

12. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

13. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

14. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☒ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☒ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

No

19. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

Neuroptics Invoice for Pupillometer Kit: Includes a Pupillometer, a charging station, eye cups (2), power supply adapter, instructions for use, carrying case, and Matlab scripts (one for data and one for video).

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

10 years

22. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

23. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

Pupillometer Kit Default equipment formula

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:
    N/A (This is not a PE only code)

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:
    N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	K	L
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**		**RECOMMENDED**	
2						**92082**		**95919**	
3		***RUC Collaboration Website***				Visual field examination, unilateral or bilateral, with interpretation and report; intermediate		Quantitative pupillometry with physician or qualified health care professional	
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 9 Quantitative Pupillometry Services Specialties: AAO, AAP**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 17.68**	**$ -**	**$ 3.14**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A		0.38	**27.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**8.0**	**0.0**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**27.0**	**0.0**	**0.0**	**0.0**
13		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**8.0**	**0.0**
14		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**
15		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
16		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 10.26**	**$ -**	**$ 2.96**	**$ -**
17		**PRE-SERVICE PERIOD**							
18		**Start: Following visit when decision for surgery/procedure made**							
19	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37				
20	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37				
21	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37				
22	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37				
23	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37				
24	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37				
25	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37				
26	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37				
27			L037D	RN/LPN/MTA	0.37				
30		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37				
33		**End: When patient enters office/facility for surgery/procedure**							
34		**SERVICE PERIOD**							
35		**Start: When patient enters office/facility for surgery/procedure:**							
36		**Pre-Service (of service period)**							
37	CA009	Greet patient, provide gowning, ensure appropriate medical records are available	L037D	RN/LPN/MTA	0.37				
38	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37				
39	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37				
40	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37				
41	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37				
42	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37				
43	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37				
44	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L038A	COMT/COT/RN/CST	0.38	2			
45	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37			2	
46	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37				
47			L037D	RN/LPN/MTA	0.37				
50		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37				
53		**Intra-service (of service period)**							
54	CA018	Assist physician or other qualified healthcare professional---directly related to physician work time (100%)	L038A	COMT/COT/RN/CST	0.38	20			
55	CA019	Assist physician or other qualified healthcare professional---directly related to physician work time (67%)	L037D	RN/LPN/MTA	0.37				
56	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other%)	L037D	RN/LPN/MTA	0.37				
57	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37			3	
60			L037D	RN/LPN/MTA	0.37				
61		*Other activity: please include short clinical description here and type new in col/row A*	L037D	RN/LPN/MTA	0.37				
64		**Post-Service (of service period)**							
65	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37				
66	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37				
67	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37			1	
68	CA025	Clean scope	L037D	RN/LPN/MTA	0.37				
69	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37				
70	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37				
71	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37			2	
72	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37				
73	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page	L037D	RN/LPN/MTA	0.37				
74	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37				
75	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue	L037D	RN/LPN/MTA	0.37				
76	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37				
77	CA034	Document procedure (non-PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)	L038A	COMT/COT/RN/CST	0.38	5			

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4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 9 Quantitative Pupillometry Services Specialties: AAO, AAP**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 17.68**	**$ -**	**$ 3.14**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A		0.38	**27.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**8.0**	**0.0**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**27.0**	**0.0**	**0.0**	**0.0**
13		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**8.0**	**0.0**
14		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**
15		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
78	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37				
79	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**	
80			L037D	RN/LPN/MTA	0.37				
83		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37				
86		**End: Patient leaves office/facility**							
87		**POST-SERVICE PERIOD**							
88		**Start: Patient leaves office/facility**							
89	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37				
90	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37				
91		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**
92		99211 16 minutes	16						
93		99212 27 minutes	27						
94		99213 36 minutes	36						
95		99214 53 minutes	53						
96		99215 63 minutes	63						
97	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
98			L037D	RN/LPN/MTA	0.37				
101		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37				
104		**End: with last office visit before end of global period**							

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3		***RUC Collaboration Website***				Visual field examination, unilateral or bilateral, with interpretation and report; intermediate		Quantitative pupillometry with physician or qualified health care professional	
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 9 Quantitative Pupillometry Services Specialties: AAO, AAP**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**				
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 17.68**	**$ -**	**$ 3.14**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L038A		0.38	**27.0**	**0.0**	**0.0**	**0.0**
9		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**8.0**	**0.0**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**27.0**	**0.0**	**0.0**	**0.0**
13		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**8.0**	**0.0**
14		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L038A	COMT/COT/RN/CST	0.38	**0.0**	**0.0**	**0.0**	**0.0**
15		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**
105	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**					
106		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ 1.61**	**$ -**	**$ 0.03**	**$ -**
107	SD103	occluder, clip-on	1.6055	item		1			
108	SJ053	swab-pad, alcohol	0.0333	item				1	
109		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*							
111	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**				
112		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ 5.81**	**$ -**	**$ 0.14**	**$ -**
113	EQ029	Humphrey field analyzer	27913.3927	Default	0.08766786	27			
114	EL006	lane, screening (oph)	39874.4787	Default	0.125234158	27			
115	EQ165	lens set, trial, full diameter, w-frame	904.93	Default	0.002401437	27			
116									
117	NEW	*Pupillometer Kit*	8995.00	Default	0.02387027			6	

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2021

Inpatient and Observation Care Services – Tab 10

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work for health care providers and improve health outcomes for patients. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel deleted seven observation care codes and revised eleven codes to merge inpatient and observation care and to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visits, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient hospital or observation care visit code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The inpatient and observation care services were surveyed for the October 2021 RUC meeting. The survey time captured the total time on the date of encounter by calendar date.

In October 2021, the RUC referred these services to be resurveyed because the survey did not include a request for distinct time before and after floor/unit time, therefore could not be compared to previous RUC surveys of these services. The specialty societies will revise their survey instrument by working with the Research Subcommittee. **The RUC will review the inpatient and observation care services (99221-99223, 99231-99236 and 99238-99239) at the January 2022 RUC meeting.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Office or Other Outpatient Services** **Established Patient**				
▲99211		**Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. ~~Usually, the presenting problem(s) are minimal~~		
Hospital Observation Services				
~~The following codes are used to report evaluation and management services provided to patients designated/ admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital.~~				
~~If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc.), these codes are to be utilized if the patient is placed in such an area.~~				
~~For definitions of key components and commonly used terms, please see **Evaluation and Management Services Guidelines.**~~				
~~***Coding Tip***~~				
~~**The Significance of Time as a Factor in Selection of an Evaluation and Management Code**~~				
~~The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services included in codes in this section. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.~~				
~~**Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99251, 99252, 99253, 99254, 99255], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]):**~~				
~~For coding purposes, time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.~~				
~~CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Time~~				
Observation Care Discharge Services				
~~Observation care discharge of a patient from "observation status" includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records. For observation or inpatient hospital care including the admission and discharge of the patient on the same date, see codes 99234-99236 as appropriate.~~				

~~99217~~	-	~~**Observation care discharge** day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])~~ (99217 has been deleted. To report observation care discharge services, see 99238, 99239)	~~XXX~~	~~N/A~~

Initial Observation Care
New or Established Patient

~~The following codes are used to report the encounter(s) by the supervising physician or other qualified health care professional with the patient when designated as outpatient hospital "observation status." This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments. For observation encounters by other physicians, see office or other outpatient consultation codes (99241-99245) or subsequent observation care codes (99224-99226) as appropriate.~~

~~To report services provided to a patient who is admitted to the hospital after receiving hospital observation care services on the same date, see the notes for initial hospital inpatient care (page 15). For observation care services on other than the initial or discharge date, see subsequent observation services codes (99224-99226). For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported with the appropriate initial hospital care code (99221-99223). For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate. Do not report observation discharge (99217) in conjunction with a hospital admission (99221-99223).~~

~~When "observation status" is initiated in the course of an encounter in another site of service (eg, hospital emergency department, office, nursing facility) all evaluation and management services provided by the supervising physician or other qualified health care professional in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service reported by the supervising physician or other qualified health care professional should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting.~~

~~Evaluation and management services including new or established patient office or other outpatient services (99201-99215), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), home services (99341-99350), and preventive medicine services (99381-99429) on the same date related to the admission to "observation status" should not be reported separately.~~

~~These codes may not be utilized for post-operative recovery if the procedure is considered part of the surgical "package." These codes apply to all evaluation and management services that are provided on the same date of initiating "observation status."~~

~~99218~~	-	**~~Initial observation care~~**~~, per day, for the evaluation and management of a patient which requires these 3 key components:~~ • **~~A detailed or comprehensive history;~~** • **~~A detailed or comprehensive examination; and~~** • **~~Medical decision making that is straightforward or of low complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.~~	~~XXX~~	~~N/A~~
~~99219~~	-	**~~Initial observation care~~**~~, per day, for the evaluation and management of a patient which requires these 3 key components:~~ • **~~A comprehensive history;~~** • **~~A comprehensive examination; and~~** • **~~Medical decision making of moderate complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.~~	~~XXX~~	~~N/A~~

~~99220~~	-	**~~Initial observation care~~**~~, per day, for the evaluation and management of a patient which requires these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ (99218, 99219, 99220 have been deleted. To report initial observation care, new or established patient, see 99221, 99222, 99223)	~~XXX~~	~~N/A~~
Subsequent Observation Care ~~All levels of subsequent observation care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment.~~				
~~99224~~	-	**~~Subsequent observation care,~~**~~ per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:~~ • ~~**Problem focused interval history;**~~ • ~~**Problem focused examination;**~~ • ~~**Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.~~	~~XXX~~	~~N/A~~

~~99225~~	-	~~**Subsequent observation care,** per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:~~ ~~• **An expanded problem focused interval history;**~~ ~~• **An expanded problem focused examination;**~~ ~~• **Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.~~	~~XXX~~	~~N/A~~
~~99226~~	-	~~**Subsequent observation care,** per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:~~ ~~• **A detailed interval history;**~~ ~~• **A detailed examination;**~~ ~~• **Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ (99224, 99225, 99226 have been deleted. To report subsequent observation care, see 99231, 99232, 99233)	~~XXX~~	~~N/A~~

Hospital Inpatient and Observation Care Services

The following codes are used to report initial and subsequent evaluation and management services provided to hospital inpatients and to patients designated as hospital outpatient "observation status". ~~Hospital inpatient and observation care services include those services provided to patients in a "partial hospital" setting.~~ Hospital inpatient or observation care codes are to be used to report these partial hospitalization services. ~~These are to be used to report these partial hospitalization services. See also **psychiatry** notes in the full text of the CPT code set~~.

For patients designated/admitted as "observation status" in a hospital, it is not necessary that the patient be located in an observation area designated by the hospital. If such an area does exist in a hospital (as a separate unit in the hospital, in the emergency department, etc), these codes may be utilized if the patient is placed in such an area.

For definitions of ~~key components and~~ commonly used terms, see **Evaluation and Management Services Guidelines.** ~~For Hospital Observation Services, see 99218-99220, 99224-99226.~~ For a patient admitted and discharged from ~~observation or~~ hospital inpatient or observation status on the same date, ~~the services should be~~ report~~ed with codes~~ 99234, 99235, ~~-~~99236 as appropriate.

~~***Coding Tip***~~

~~**The Significance of Time as a Factor in Selection of an Evaluation and Management Code**~~

~~The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services included in codes in this section. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.~~

~~**Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99251, 99252, 99253, 99254, 99255], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]):**~~

~~For coding purposes, time for these services is defined as unit/floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.~~

~~*CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Time*~~

Total time on the date of the encounter is by calendar date. When using MDM or time for code selection, a continuous service that spans the transition of two calendar dates is a single service and is reported on one date. If the service is continuous before and through midnight, all the time may be applied to the reported date of the service.

Initial Hospital Inpatient or Observation Care
New or Established Patient

The following codes are used to report the first hospital inpatient or observation status encounter with the patient ~~by the admitting physician~~.

~~For initial inpatient encounters by physicians other than the admitting physician, see initial inpatient consultation codes (99251-99255) or subsequent hospital care codes (99231-99233) as appropriate.~~

An initial service may be reported when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and subspecialty as the physician.

For admission services for the neonate (28 days of age or younger) requiring intensive observation, frequent interventions, and other intensive care services, see 99477.

When the patient is admitted to the hospital as an inpatient or to observation status in the course of an encounter in another site of service (eg, hospital emergency department, ~~observation status in a hospital,~~ office, nursing facility), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or qualified health care professional was performed on the same date. ~~all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission. The inpatient care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the inpatient setting.~~

In the case when the services in a separate site are reported and the initial inpatient or observation care service is a consultation service, do not report 99221, 99222, 99223, 99252, 99253, 99254, or 99255. The consultant reports the subsequent hospital inpatient or observation care codes 99231, 99232, 99233 for the second service on the same date.

~~Evaluation and management services including new or established patient office or other outpatient services (99201-99215), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), home services (99341-99350), and preventive medicine services (99381-99397) on the same date related to the admission to "observation status" should **not** be reported separately.~~

~~For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate.~~

If a consultation is performed in anticipation of, or related to, an admission by another ~~professional~~ physician or other qualified health care professional, and then the same consultant performs an encounter once the patient is admitted by the other physician or qualified health care professional, report the consultant's inpatient encounter with the appropriate subsequent care code (99231, 99232, 99233) ~~for the initial encounter for the stay~~. This instruction applies whether the consultation occurred on the date of the admission or a date previous to the admission. It also applies for consultations reported with any appropriate code (eg, office or other outpatient visit or office or other outpatient consultation).

For a patient admitted and discharged from observation or inpatient status on the same date, report 99234, 99235, 99236 as appropriate.

For the purposes of reporting an initial hospital or observation care service a transition from observation level to inpatient does not constitute a new stay.

▲99221	F1	**Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. ~~these 3 key components:~~ • ~~**A detailed or comprehensive history;**~~ • ~~**A detailed or comprehensive examination; and**~~ • ~~**Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Resurvey for January 2022 (2021 work RVU = 1.92)
▲99222	F2	**Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Resurvey for January 2022 (2021 work RVU = 2.61)

▲99223	F3	**Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded. (For services of ZZ or longer, use prolonged services code 993X0)	XXX	Resurvey for January 2022 (2021 work RVU = 3.86)

Subsequent Hospital Inpatient or Observation Care ~~All levels of subsequent hospital care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition and response to management) since the last assessment.~~				
▲99231	F4	**Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A problem focused interval history;**~~ • ~~**A problem focused examination;**~~ • ~~**Medical decision making that is straight forward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Resurvey for January 2022 (2021 work RVU = 0.76)

▲99232	F5	**Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**An expanded problem focused interval history;**~~ • ~~**An expanded problem focused examination;**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Resurvey for January 2022 (2021 work RVU = 1.39)
▲99233	F6	**Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A detailed examination;**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded. (For services of ZZ or longer, use prolonged services code 993X0)	XXX	Resurvey for January 2022 (2021 work RVU = 2.00)

Hospital Inpatient or Observation ~~or Inpatient~~ Care Services (Including Admission and Discharge Services)

The following codes are used to report ~~observation or inpatient~~ hospital inpatient or observation care services provided to patients admitted and discharged on the same date of service.

~~When a patient is admitted to the hospital from observation status on the same date, only the initial hospital care code should be reported. The initial hospital care code reported by the admitting physician or other qualified health care professional should include the services related to the observation status services he/she provided on the same date of inpatient admission.~~

~~When "observation status" is initiated in the course of an encounter in another site of service (eg, hospital emergency department, office, nursing facility) all evaluation and management services provided by the supervising physician or other qualified health care professional in conjunction with initiating "observation status" are considered part of the initial observation care when performed on the same date. The observation care level of service should include the services related to initiating "observation status" provided in the other sites of service as well as in the observation setting when provided by the same individual.~~

For patients admitted to hospital inpatient or observation ~~or inpatient~~ care and discharged on a different date, see ~~codes 99217, 99218-99220, 99224-99226, or~~ 99221, 99222, ~~-~~99223, 99231, 99232, 99233, 99238, ~~and~~ 99239.

Codes 99234, 99235, 99236 require two or more encounters on the same date of which one of these encounters is an initial admission encounter and another encounter being a discharge encounter. For a patient admitted and discharged at the same encounter, see 99221, 99222, 99223. Do not report 99238, 99239 in conjunction with 99221, 99222, 99223 for admission and discharge services performed on the same date.

(For discharge services provided to newborns admitted and discharged on the same date, use 99463)

▲99234	F7	**Hospital inpatient or ~~O~~observation ~~or inpatient hospital~~ care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. ~~these 3 key components:~~ • ~~**A detailed or comprehensive history;**~~ • ~~**A detailed or comprehensive examination; and**~~ • ~~**Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.~~	XXX	Resurvey for January 2022 (2021 work RVU = 2.56)

		When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.		
▲99235	F8	**Hospital inpatient or ~~O~~observation ~~or inpatient hospital~~ care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Resurvey for January 2022 (2021 work RVU = 3.24)
▲99236	F9	**Hospital inpatient or ~~O~~observation ~~or inpatient hospital~~ care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.~~	XXX	Resurvey for January 2022 (2021 work RVU = 4.20)

		When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded. (For services of ZZ or longer, use prolonged services code 993X0)		
Hospital Inpatient or Observation Discharge Services The hospital inpatient or observation discharge day management codes are to be used to report the total duration of time spent by a physician or other qualified health care professional for final hospital discharge of a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, ~~even if the time spent by the physician on that date is not continuous,~~ instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. These codes are to be utilized to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient or observation status. For a patient admitted and discharged from hospital inpatient or observation ~~or inpatient~~ status on the same date, ~~the services should be~~ report~~ed with codes~~ 99234, 99235, ~~-~~99236 as appropriate. Codes 99238, 99239 are to be used by the physician or other qualified health care professional who is responsible for discharge services. Services by other physicians or other qualified health care professionals that may include instructions to the patient and/or family and coordination of post discharge services may be reported with 99231, 99232, 99233.				
▲99238	F10	Hospital inpatient or observation discharge day management**;** 30 minutes or less	XXX	Resurvey for January 2022 (2021 work RVU = 1.28)
▲99239	F11	more than 30 minutes ~~(These codes are to be utilized to report all services provided to a patient on the date of discharge, if other than the initial date of inpatient or observation status. To report services to a patient who is admitted as an inpatient and discharged on the same date, see codes 99234, 99235, 99236 for observation or inpatient hospital care including the admission and discharge of the patient on the same date. To report concurrent care services provided by an individual other than the physician or qualified health care professional performing the discharge day management service, use subsequent hospital care codes [99231-99233] on the day of discharge.)~~ ~~(For Observation Care Discharge, use 99217)~~ (For hospital inpatient or observation ~~or inpatient hospital~~ care including the admission and discharge of the patient on the same date, see 99234-99236) ~~(For Nursing Facility Care Discharge, see 99315, 99316)~~ *(For discharge services provided to newborns admitted and discharged on the same date, use 99463)*	XXX	Resurvey for January 2022 (2021 work RVU = 1.90)

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2021

Consultations – Tab 11

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel deleted two consultation codes and revised eight consultation codes to align with the principles included in the office or other outpatient E/M services (99202-99215) by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visits, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of an inpatient consultation or outpatient consultation code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing the patient are summed to select the appropriate code. The inpatient consultation and outpatient consultation services were surveyed for the October 2021 RUC meeting. The inpatient consultation survey time captured the total time on the date of encounter by calendar date. Aligning with the 2019 office visit survey process, the office or other outpatient consultation survey time captured includes pre-service time 3-days before the date of encounter, intra-service time is all the time on the date of encounter and post-service time is 7-days after the date of encounter.

Office or Other Outpatient Consultations

Although the recommended work RVUs for codes 99242-99245 are not greater than the current values, the specialty societies noted and the RUC agreed that the compelling evidence of change in technology that supported the increased work RVUs for the office visit codes (99202-99215) also provides support for an increase in intensity of work for office consultation codes. Specifically, According to National Medical Ambulatory Care Survey (NAMCS) data, in 2015, 76% of all practices used electronic health records exclusively, 11% used them partially, and 12% used only paper records. In 2008 the corresponding numbers were 29%, 17%, and 53%. All remarkable differences demonstrating that the technology used to deliver office-based care has changed dramatically. This is confirmed by the CDC, which estimates that use of an EHR increased from 35% in 2007 to 87% in 2015. The EHR contains more data than paper records, most of which must be reviewed including for drug-drug and, with increasing use of homeopathic substances, drug substance interactions. In addition, the presenters provided information that consultations carry

more liability due to the expert opinion provided. Since the inception of the Medicare Physician Fee Schedule, the work RVUs for the office consultation codes have always been higher than the office visit E/M codes; the Harvard study acknowledged a relative difference in work in 1991 and the RUC confirmed a relative difference in work in 2006.

99242 ***Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.***
The RUC reviewed the survey results from 213 physicians and other qualified health care professionals and determined the survey median work RVU of 1.08 appropriately accounts for the physician work required to perform this service. The RUC recommends 30 minutes total time. The RUC noted that CPT code 99241 has been deleted and some or all its previous utilization will now be reported with CPT code 99242. The 2009 Medicare utilization of CPT code 99241 was only 21 percent of that of the Medicare utilization for 99242, thus the typical patient for a 99242 will not change.

The specialties noted, and the RUC concurred, that office or other outpatient consultation codes should be valued somewhat higher than the analogous office or other outpatient new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. The report would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests.

To justify a work RVU of 1.08, the RUC compared the surveyed code to the top key reference service 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93, 20 minutes total time) and determined that CPT code 99242 typically requires more physician work and time, thus would be valued appropriately with a work value of 1.08. The RUC also compared the surveyed code to MPC code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU= 1.30, 30 minutes total time) and noted that although both services involve an identical amount of total time, the surveyed code involves a lower level of medical decision making relative to the reference code (straightforward vs. low), and therefore would have appropriate relativity with this reference service. **The RUC recommends a work RVU of 1.08 for CPT code 99242.**

99243 ***Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***
The RUC reviewed the survey results from 234 physicians and other qualified health care professionals and determined that the survey median work RVU of 1.80 appropriately accounts for the physician work required to perform this service. The RUC recommends 44 minutes total time.

The specialties noted, and the RUC concurred, that office or other outpatient consultation codes should be valued somewhat higher than the analogous office or other outpatient new patient visit with the same level of medical decision making to account for the work of generating and

sending a written report to the requesting physician. The report would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests.

To justify a work RVU of 1.80, the RUC compared the surveyed code to the top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60, 35 minutes total time) and determined that CPT code 99243 typically requires more physician work and time, thus would be valued appropriately higher with a work value of 1.80. The RUC also compared the surveyed code to the second top key reference code 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU= 1.30, 30 minutes total time) and noted that the surveyed code involves 14 more minutes of total time and both services are for a low level of medical decision making. In addition, surveyed code 99243 is typically for a new patient, whereas reference code 99213 is for an established patient. The RUC concurred that assigning 99243 a value of 1.80 would maintain relativity with the current value for 99213. **The RUC recommends a work RVU of 1.80 for CPT code 99243.**

99244 ***Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.***

The RUC reviewed the survey results from 248 physicians and other qualified health care professionals and determined that a work RVU of 2.69, a value between the survey 25th percentile and survey median would most appropriately account for the physician work required to perform this service. The RUC recommends 60 minutes total time.

After thorough discussion, the RUC recommends a direct work RVU crosswalk to CPT code 93315 *Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report* (work RVU= 2.69, intra-service time of 40 minutes, total time of 65 minutes), agreeing that both services involve similar total time and similar relative physician work. The RUC also compared the surveyed code to top key reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU= 2.60, total time of 60 minutes) and concurred that 99244 should be valued with a slightly higher intensity and higher work RVU relative to 99204 and referenced that 63 percent of the survey respondents that selected this top key reference service had indicated that 99244 is more intense/complex.

The specialties noted, and the RUC concurred, that office or other outpatient consultation codes should be valued somewhat higher than the analogous office or other outpatient new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. The report would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests. The specialties also noted that a consultation typically involves a greater amount of data to review at the moderate level decision-making level relative to the analogous new patient office visit code 99204. The RUC concluded that CPT code 99244 should be valued based on a direct work RVU crosswalk to CPT code 93315 which falls between the median and 25th percentile as supported by the survey. **The RUC recommends a work RVU of 2.69 for CPT code 99244.**

99245 ***Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.***
The RUC reviewed the survey results from 231 physicians and other qualified health care professionals and determined that the survey median work RVU of 3.75 appropriately accounts for the physician work required to perform this service. The RUC recommends 87 minutes total time.

To justify a work RVU of 3.75, the RUC compared the surveyed code to top key reference code 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter* (work RVU= 3.50, total time of 88 minutes) and concurred that 99245 should be valued with a slightly higher intensity relative to 99205 and referenced that 67 percent of the survey respondents that selected this top key reference service had indicated that 99245 is more intense/complex. The specialties noted, and the RUC concurred, that office or other outpatient consultation codes should be valued somewhat higher than the analogous office or other outpatient new patient visit with the same level of medical decision making to account for the work of generating and sending a written report to the requesting physician. The report would provide recommendations for the management of the patient and identify additional labs, imaging and/or tests. The specialties also noted that a consultation typically involves a greater amount of data to review at the high-level decision-making level relative to the analogous new patient office visit code 99205.

The RUC referenced CPT code 95720 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)* (work RVU= 3.86, intra-service time of 55 minutes, total time of 75 minutes) and CPT code 44390 *Colonoscopy through stoma; with removal of foreign body(s)* (work RVU= 3.74, intra-service time of 35 minutes, total time of 77 minutes) and noted that the surveyed code involves more total time, though a similar amount of physician work to these reference services. **The RUC recommends a work RVU of 3.75 for CPT code 99245.**

Inpatient and Observation Consultations
In October 2021, the RUC referred the inpatient and observation consultation services to be resurveyed, because the survey did not include a request for distinct time before and after floor/unit time, and therefore could not be compared to previous RUC surveys of these services. The specialty societies will revise their survey instrument by working with the Research Subcommittee. **The RUC will review the inpatient consultation services CPT codes 99252, 99253, 99254 and 99255 at the January 2022 RUC meeting.**

CPT Descriptor Time for Outpatient Consultations
The RUC recommends the following total times on the date of encounter for the outpatient consultation CPT descriptors based on the survey medians. The times in the CPT descriptors are rounded or incremental between this family of services for the ease of those who may report these services based on time.

CPT Code		Time on the Date of Encounter Recommendation to CPT
99242	Office or Other Outpatient Consultation, new or est pt, straightforward MDM	20
99243	Office or Other Outpatient Consultation, new or est pt, low MDM	30
99244	Office or Other Outpatient Consultation, new or est pt, moderate MDM	40
99245	Office or Other Outpatient Consultation, new or est pt, high MDM	55

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expense inputs for outpatient consultation and made no modifications. **The RUC recommends the outpatient consultation direct practice expense inputs as submitted by the specialty societies.** The practice expense for the inpatient consultation codes will be reviewed at the January 2022 RUC meeting.

Work Neutrality

Based on the 2009 Medicare utilization data from when these services were last covered by Medicare, the RUC's recommendation for this family of codes would have resulted in an overall work savings.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Consultations** A consultation is a type of evaluation and management service provided at the request of another physician, other qualified health care professional, or appropriate source to ~~either~~ recommend care for a specific condition or problem ~~or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem~~. A physician or other qualified health care professional consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit. A "consultation" initiated by a patient and/or family, and not requested by a physician, other qualified health care professional, or other appropriate source (eg, ~~physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech-language pathologist, psychologist,~~ non-clinical social worker, educator, lawyer, or insurance company), is not reported using the consultation codes ~~but may be reported using the office visit, home service, or domiciliary/rest home care codes as appropriate~~.				

~~The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source.~~ The consultant's opinion and any services that were ordered or performed must also be ~~documented in the patient's medical record and~~ communicated by written report to the requesting physician, other qualified health care professional, or other appropriate source.

If a consultation is mandated (eg, by a third-party payer) modifier 32 should also be reported.

~~Any specifically identifiable procedure (ie, identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately.~~

~~If subsequent to the completion of a consultation the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the appropriate **Evaluation and Management** services code for the site of service should be reported. In the hospital or nursing facility setting, the consultant should use the appropriate inpatient consultation code for the initial encounter and then subsequent hospital or nursing facility care codes. In the office setting, the consultant should use the appropriate office or other outpatient consultation codes and then the established patient office or other outpatient services codes.~~

To report services when ~~provided to~~ a patient ~~who~~ is admitted to ~~a~~ hospital inpatient, or observation status, or to a nursing facility in the course of an encounter in another setting ~~the office or other ambulatory facility~~, see ~~the notes for~~ **Initial Hospital Inpatient or Observation Care** ~~(page 23)~~ or **Initial Nursing Facility Care** ~~(page 33)~~.

For definitions of ~~key components and~~ commonly used terms, ~~please~~ see **Evaluation and Management Services Guidelines.**

Office or Other Outpatient Consultations
New or Established Patient

The following codes may be ~~are~~ used to report consultations ~~to new patients~~ that are provided in the office or other outpatient site ~~in an outpatient or other ambulatory facility, including hospital observation services~~, including the home or residence, ~~services, domiciliary, rest home,~~ or emergency department ~~(see the preceding consultation definition above)~~. Follow-up visits in the consultant's office or other outpatient facility that are initiated by the consultant or patient are reported using the appropriate codes for established patients in the office ~~visits~~ (99212, 99213, 99214, ~~-~~99215), home, or residence (99347, 99348, 99349, 99350)~~, domiciliary, rest If an additional request for an opinion or advice regarding the same or a new problem is received from another physician, or other appropriate source and documented in the medical record, the office consultation codes may be used again~~.

Services that constitute transfer of care (ie, are provided for the management of the patient's entire care or for the care of a specific condition or problem) are reported with the appropriate new or established patient codes for office or other outpatient visits, ~~domiciliary, rest home services,~~ or home or residence services.

(For an outpatient consultation requiring prolonged services, use 99417)

~~***Coding Tip***~~

~~Definition of Transfer of Care~~

~~Transfer of care is the process whereby a physician or other qualified health care professional who is providing management for some or all of a patient's problems relinquishes this responsibility to another physician or other qualified health care professional who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician or other qualified health care professional transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician or other qualified health care professional who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.~~

~~CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Concurrent Care and Transfer of Care~~

~~99241~~	-	~~**Office consultation** for a new or established patient, which requires these 3 key components:~~ • ~~**A problem focused history;**~~ • ~~**A problem focused examination; and**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.~~ (99241 has been deleted. To report, use 99242)	~~XXX~~	~~N/A~~
▲99242	G1	**Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. ~~these 3 key components:~~ • ~~**An expanded problem focused history;**~~ • ~~**An expanded problem focused examination; and**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	XXX	1.08

▲99243	G2	**Office <u>or other outpatient</u> consultation** for a new or established patient, which requires <u>a medically appropriate history and/or examination and low level of medical decision making.</u> ~~these 3 key components:~~ • ~~**A detailed history;**~~ • ~~**A detailed examination; and**~~ • ~~**Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.</u>	XXX	1.80

▲99244	G3	**Office <u>or other outpatient</u> consultation** for a new or established patient, which requires <u>a medically appropriate history and/or examination and moderate level of medical decision making.</u> ~~these 3 key components:~~ ~~• **A comprehensive history;**~~ ~~• **A comprehensive examination; and**~~ ~~• **Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.</u>	XXX	2.69

▲99245	G4	**Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components:~~ ~~• **A comprehensive history;**~~ ~~• **A comprehensive examination; and**~~ ~~• **Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded. (For services 70 minutes or longer, use prolonged services code 99417)	XXX	3.75

Inpatient or Observation Consultations
New or Established Patient

~~The following~~ ~~c~~Codes 99252, 99253, 99254, 99255 are used to report physician or other qualified health care professional consultations provided to hospital inpatients, observation level patients, residents of nursing facilities, or patients in a partial hospital setting and when the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and subspecialty as the physician.

Only one consultation ~~should~~ may be reported by a consultant per admission. Subsequent consultation services during the same admission are reported using subsequent hospital inpatient or observation care codes (99231-99233) or subsequent nursing facility care codes (99307-99310).~~, including services to complete the initial consultation, monitor progress, revise recommendations, or address a new problem. Use subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310) to report transfer of care services (see page 5, Concurrent Care and Transfer of Care definitions).~~

~~When an inpatient consultation is performed on a date that a patient is admitted to a hospital or nursing facility all evaluation and management services provided by the consultant related to the admission are reported with the inpatient consultation service code (99251-99255). If a patient is admitted after an outpatient consultation (office, emergency department, etc), and the patient is not seen on the unit on the date of admission, only report the outpatient consultation code (99241-99245). If the patient is seen by the consultant on the unit on the date of admission, report all evaluation and management services provided by the consultant related to the admission with either the inpatient consultation code (99251-99255) or with the initial inpatient admission service code (99221-99223). Do not report both an outpatient consultation (99241-99245) and inpatient consultation (99251-99255) for services related to the same inpatient stay. When transfer of care services are provided on a date subsequent to the outpatient consultation, use the subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310).~~

(For an inpatient or observation consultation requiring prolonged services, use 993X0)

~~99251~~	-	**~~Inpatient consultation~~** ~~for a new or established patient, which requires these 3 key components:~~ • ~~**A problem focused history;**~~ • ~~**A problem focused examination; and**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ (99251 has been deleted. To report, use 99252)	~~XXX~~	~~N/A~~
▲99252	G5	**Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. ~~these 3 key components:~~ • ~~**An expanded problem focused history;**~~ • ~~**An expanded problem focused examination; and**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Resurvey for January 2022 (2021 work RVU = 1.50)

▲99253	G6	**Inpatient or observation consultation** for a new or established patient, which requires t a medically appropriate history and/or examination and low level of medical decision making. ~~these 3 key components:~~ • ~~**A detailed history;**~~ • ~~**A detailed examination; and**~~ • ~~**Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Resurvey for January 2022 (2021 work RVU = 2.27)

▲99254	G7	**Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ ~~• **A comprehensive history;**~~ ~~• **A comprehensive examination; and**~~ ~~• **Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX	Resurvey for January 2022 (2021 work RVU = 3.29)

▲99255	G8	**Inpatient <u>or observation</u> consultation** for a new or established patient, which requires <u>a medically appropriate history and/or examination and high level of medical decision making.</u> ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.</u> <u>(For services ZZ minutes or longer, use prolonged services code 993X0)</u>	XXX	Resurvey for January 2022 (2021 work RVU = 4.00)

CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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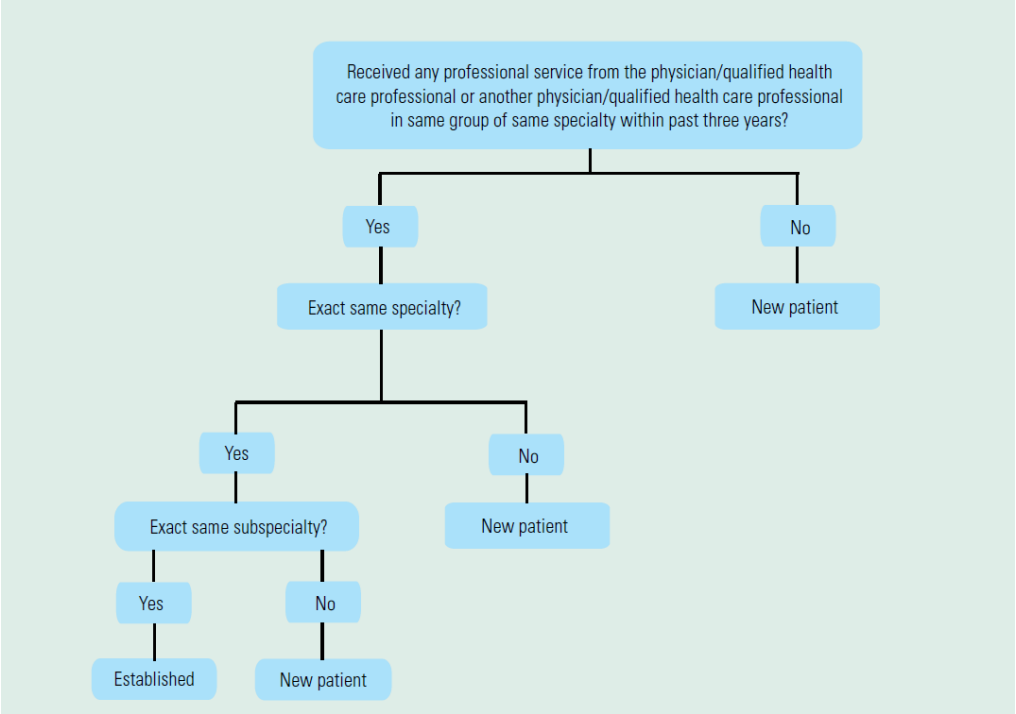
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99242 Tracking Number G1 Original Specialty Recommended RVU: **1.08**
Presented Recommended RVU: **1.08**
Global Period: XXX Current Work RVU: **1.34** RUC Recommended RVU: **1.08**

CPT Descriptor: Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A requested office consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be self-limited. A report is generated and sent to the requesting provider.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Physician/QHP typical activities performed within 3 calendar days prior to the Office or Outpatient Consultation and within 7 calendar days after the day of the consultation include: Review the referring physician/QHP request for the consultant's expert opinion regarding evaluation and/or management of a specific medical problem. Document the request for the consultation in the medical record. Obtain and review prior medical records, including labs and imaging, if available. Order and review additional diagnostic labs, imaging and/or other tests, as needed. Incorporate pertinent information into the medical record. Review the medical history forms completed by the patient. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Perform a medically appropriate examination. Synthesize the relevant history, physical examination and tests to formulate a differential diagnosis requiring straightforward MDM. Discuss the findings with the patient and family and respond to patient and family questions. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Generate and a written report that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient to the requesting provider. Document the report in the medical record. Communicate with other members of the health care team regarding the visit. Respond to follow-up questions from the requesting physician/QHP and patient/family.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Don Selzer, MD, FACS; Marianna Spanaki, MD, PhD; Phillip Rodgers, MD FAAHPM					
Specialty Society(ies):	AADA, AAN, AANS, CNS, AAOS, AAP, AAHPM, ACC, ACG, AGA, ASGE, ACOG, ACR, ACS, ASCO, ASCRS, ASSH, ACNM, ATS, ACCP, NASS, SNMMI, STS, AATS, SVS					
CPT Code:	99242					
Sample Size:	35232	**Resp N:**	213			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**5.00**	20.00	750.00	
Survey RVW:	0.18	0.93	**1.08**	1.49	3.85	
Pre-Service Evaluation Time:			**5.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	2.00	15.00	**20.00**	25.00	45.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99242	**Recommended Physician Work RVU: 1.08**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99202	XXX	0.93	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.70	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	2,490,658

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.60	**RUC Time**	11,452,897

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 109 **% of respondents:** 51.1 **%**

Number of respondents who choose 2nd Key Reference Code: 36 **% of respondents:** 16.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 99242	Top Key Reference CPT Code: 99202	2nd Key Reference CPT Code: 99212
Median Pre-Service Time	5.00	2.00	2.00
Median Intra-Service Time	20.00	15.00	11.00
Median Immediate Post-service Time	5.00	3.00	3.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**20.00**	**16.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	2%	3%	64%	30%	1%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	66%	28%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	81%	16%
Physical effort required	5%	79%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	64%	28%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	58%	31%	6%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	58%	36%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	75%	17%
Physical effort required	8%	75%	17%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	69%	25%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background – Office Consultation Services (99242-99245)

CPT 2023 Changes

At the February 4-5, 2021 CPT virtual meeting, the following changes to the office consultation codes were approved:

- Deletion of code 99241
- Revision of codes 99242-99245 to align with changes to office/outpatient visit codes (99202-99215) including:
  - Requiring a medically appropriate history and/or examination
  - Allowing selection of level of service based on total time or medical decision making
- Recommendation to backfill code-level minimum time based on a RUC survey

Survey Process

AMA staff and the co-chairs of the CPT/RUC E/M Workgroup drafted a survey for the office consultation codes that was based on the 2019 office visit survey. This survey template was approved by the Research Subcommittee during a conference call on February 23, 2021. On this same call, the Research Subcommittee reviewed a list of potential reference codes to assist the surveying specialties with development of the office consultation survey RSL. On May 24, 2021, the Research Subcommittee reviewed and approved a request to modify the office consultation vignettes that were drafted by the CPT/RUC E/M Workgroup for the CPT code change application. Twenty-five societies surveyed the office consultation codes. Over 200 responses for physician work were received for each code.

Surveying Societies

AADA	American Academy of Dermatology Association
AAN	American Academy of Neurology
AANS	American Association of Neurological Surgeons
CNS	Congress of Neurological Surgeons
AAOS	American Academy of Orthopaedic Surgeons
AAP	American Academy of Pediatrics
AAHPM	American Academy of Hospice and Palliative Medicine
ACC	American College of Cardiology
ACG	American College of Gastroenterology
AGA	American Gastroenterological Association
ASGE	American Society for Gastrointestinal Endoscopy
ACOG	American College of Obstetricians and Gynecologists
ACR	American College of Rheumatology
ACS	American College of Surgeons
ASCO	American Society of Clinical Oncology
ASCRS	American Society of Colon and Rectal Surgeons
ASSH	American Society for Surgery of the Hand
ACNM	American College of Nuclear Medicine
ATS	American Thoracic Society
ACCP	American College of Chest Physicians
NASS	North American Spine Society
SNMMI	Society of Nuclear Medicine and Molecular Imaging
STS	Society of Thoracic Surgeons
AATS	American Association for Thoracic Surgery
SVS	Society for Vascular Surgery

Change in Technology

Although the recommended work RVUs for codes 99242-99245 are not greater than the current values, it is important to point out that the compelling evidence that supported the increased work RVUs for the office visit codes (99202-99215) also provides support for an increase in intensity of work for office consultation codes. This change in technology is described in the RUC database RUC rationale: "*According to National Medical Ambulatory Care Survey (NAMCS) data, in 2015, 76% of all practices used electronic health records exclusively, 11% used them partially, and 12% used only paper records. In 2008 the corresponding numbers were 29%, 17%, and 53%. All remarkable differences demonstrating that the technology used to deliver office-based care has changed dramatically. This is confirmed by the CDC, which estimates that use of an EHR increased from 35% in 2007 to 87% in 2015. The EHR contains more data than paper records, most of which must be reviewed including for drug-drug and, with increasing use of homeopathic substances, drug substance interactions. The use of EHRs has increased physician work by increasing the time*

physician spend documenting the medical record. In 2016, it was estimated that for every hour spent with patients, physicians spend 2 hours on EHR and desk work, according to an Annals of Internal Medicine study. With increased consolidation of hospitals and EHR systems (EPIC and Cerner now have a combined 85% market share of 500+ bed hospitals), physicians have access to more patient information. The centralization of data is in the best interest of patients and will help support quality care. However, this centralization does increase the time that physicians spend reviewing patient information. The presenters argued that EHR adoption has led to a decrease in efficiency, which may never be fully regained."

Office Consultation Work versus Office Visit Work

Office consultation codes are more work than the analogous office visit (non-consultation) E/M codes due to the additional work to generate and send a written report to the requesting physician/QHP that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient's problem(s). In addition, consultations carry more liability due to the expert opinion provided. Since the inception of the Medicare Physician Fee Schedule, the work RVUs for the office consultation codes have always been higher than the office visit E/M codes. The Harvard study acknowledged this difference in work.[1] The RUC acknowledged this difference in work in 2006.[2]

When CMS finalized policy to no longer recognize office consultation codes for payment, the Agency noted that: "*Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.*"[3]

The AMA responded to the Agency's change in policy noting that the CPT Editorial Panel was revising coding guidelines for consultation codes to reflect instructions in the CMS Carrier Policy Manual. CPT 2010 specifically added the following text: "*The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.*"

Although CMS no longer pays for consultation services, many private payors and patients continue to recognize the consultation codes for payment. The stakeholder societies that provide consultation services recognize the difference in physician work and liability related to documentation and expert opinion and continue to advocate for payment for these services.

Recommendation – 99242

We recommend a work RVU of 1.08, which is the survey median.

- The recommended work RVU of 1.08 is 0.15 work RVUs greater than 99202 to account for the additional work to generate and send a written report to the requesting physician/QHP that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient's problem(s).
- Codes 99242 and 99202 both include straightforward medical decision making.
- Code 99242 requires more total time than 99202.
- This recommendation falls between the current work RVUs for codes 99241 and 99242.

Key Reference Code Comparison

Ref 1 99202: The respondents indicated the intensity/complexity of survey code 99242 is similar to somewhat more than reference code 99202.

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[1] Hsiao WC, et al. A National Study of Resource-Based Relative value Sales for Physician Services: Phase III Final Report. August 20, 1992. Volume 1. Table 7.8, pp 347-348.

[2] RUC Database 2006 RUC Rationale: The work of 99242 is also similar to 99203 New Office Visit, Level III. It was determined 99244 is more intense than 99205 and the recommended relativity appeared appropriate. 99245 is similar in total physician work to 99223 Initial Hospital Visit

[3] CMS MLN Matters Number MM6740. Related CR Release Date December 14, 2009. Related CR Transmittal # R1875CP

Ref 2 99212: The respondents indicated the intensity/complexity of survey code 99242 is somewhat more than reference code 99212.

CPT	DESCRIPTOR	RVW	WPUT	TOTAL TIME	PRE	INTRA	POST
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	0.93	0.047	20	2	15	3
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	0.70	0.044	16	2	11	3
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.	1.08	0.036	30	5	25	5

MPC Code Comparison

CPT	DESCRIPTOR	RVW	WPUT	TOTAL TIME	PRE	INTRA	POST
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	0.93	0.047	20	2	15	3
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.	1.08	0.036	30	5	25	5
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	1.60	0.046	35	5	25	5

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99241, 99242

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty dermatology How often? Commonly

Specialty general surgery How often? Commonly

Specialty orthopedic surgery How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare currently does not pay for office visit consult codes. If CMS agrees to revise its policy, the last page of this SoR includes the 2009 utilization and specialty distribution for code 99242 as information

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Office visit

BETOS Sub-classification Level II:
New

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99242

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99242 (2009 Medicare utilization and specialty distribution)	**1,378,035**
DERMATOLOGY	17.18%
GENERAL SURGERY	13.00%
ORTHOPEDIC SURGERY	7.98%
OTOLARYNGOLOGY	7.45%
INTERNAL MEDICINE	5.33%
GASTROENTEROLOGY	4.90%
UROLOGY	4.68%
FAMILY PRACTICE	4.64%
PODIATRY	3.98%
OPHTHALMOLOGY	3.73%
PLASTIC AND RECONSTRUCTIVE SURGERY	2.90%
CARDIOLOGY	2.51%
PHYSICIANS ASSISTANT	2.34%
NEUROSURGERY	1.74%
OBSTETRICS/GYNECOLOGY	1.71%
VASCULAR SURGERY	1.70%
PHYSICAL MEDICINE AND REHABILITATION	1.59%
NEUROLOGY	1.18%
NURSE PRACTITIONERS	1.18%
ANESTHESIOLOGY	1.15%
COLORECTAL SURGERY(FORMERLY PROCTOLOGY)	0.85%
HAND SURGERY	0.72%
DIAGNOSTIC RADIOLOGY	0.70%
RADIATION ONCOLOGY	0.64%
THORACIC SURGERY	0.61%
GENERAL PRACTICE	0.59%
PULMONARY DISEASE	0.47%
CARDIAC SURGERY	0.43%
ORAL SURGERY (DENTISTS ONLY)	0.36%
RHEUMATOLOGY	0.34%
PSYCHIATRY	0.33%
NEPHROLOGY	0.29%
INTERVENTIONAL PAIN MANAGEMENT	0.27%
OPTOMETRY	0.26%
HEMATOLOGY/ONCOLOGY	0.25%
ENDOCRINOLOGY	0.23%
INFECTIOUS DISEASE	0.23%
EMERGENCY MEDICINE	0.19%
MAXILLOFACIAL SURGERY	0.19%
ALLERGY/IMMUNOLOGY	0.18%
PATHOLOGY	0.13%
SURGICAL ONCOLOGY	0.11%
INTERVENTIONAL RADIOLOGY	0.11%
MEDICAL ONCOLOGY	0.11%
PAIN MANAGEMENT	0.08%

99242 (2009 Medicare utilization and specialty distribution)	**1,378,035**
PERIPHERAL VASCULAR DISEASE	0.07%
PEDIATRIC MEDICINE	0.06%
GYNECOLOGY/ONCOLOGY	0.06%
NUCLEAR MEDICINE	0.04%
OSTEOPATHIC MANIPULATIVE THERAPY	0.04%
GERIATRIC MEDICINE	0.04%
CRITICAL CARE (INTENSIVISTS)	0.04%
MULTISPECIALTY CLINIC OR GROUP PRACTICE	0.03%
HEMATOLOGY	0.02%
CERTIFIED CLINICAL NURSE SPECIALIST	0.02%
UNKNOWN PHYSICIAN SPECIALTY	0.01%
PREVENTIVE MEDICINE	0.01%
CRNA, ANESTHESIA ASSISTANT	0.01%
AUDIOLOGIST (BILLING INDEPENDENTLY)	0.01%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99243 Tracking Number G2 Original Specialty Recommended RVU: **1.80**
Presented Recommended RVU: **1.80**
Global Period: XXX Current Work RVU: **1.88** RUC Recommended RVU: **1.80**

CPT Descriptor: Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A requested office consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be an acute uncomplicated illness or injury. A report is generated and sent to the requesting provider.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Physician/QHP typical activities performed within 3 calendar days prior to the Office or Outpatient Consultation and within 7 calendar days after the day of the consultation include: Review the referring physician/QHP request for the consultant's expert opinion regarding evaluation and/or management of a specific medical problem. Document the request for the consultation in the medical record. Obtain and review prior medical records, including labs and imaging, if available. Order and review additional diagnostic labs, imaging and/or other tests, as needed. Incorporate pertinent information into the medical record. Review the medical history forms completed by the patient. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Perform a medically appropriate examination. Synthesize the relevant history, physical examination and tests to formulate a differential diagnosis requiring low level complexity MDM. Discuss the findings with the patient and family and respond to patient and family questions. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Generate and a written report that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient to the requesting provider. Document the report in the medical record. Communicate with other members of the health care team regarding the visit. Respond to follow-up questions from the requesting physician/QHP and patient/family.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Don Selzer, MD, FACS; Marianna Spanaki, MD, PhD; Phillip Rodgers, MD FAAHPM					
Specialty Society(ies):	AADA, AAN, AANS, CNS, AAOS, AAP, AAHPM, ACC, ACG, AGA, ASGE, ACOG, ACR, ACS, ASCO, ASCRS, ASSH, ACNM, ATS, ACCP, NASS, SNMMI, STS, AATS, SVS					
CPT Code:	99243					
Sample Size:	35232	**Resp N:**	234			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**20.00**	100.00	3000.00	
Survey RVW:	0.40	1.60	**1.80**	2.00	38.00	
Pre-Service Evaluation Time:			**7.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	3.00	20.00	**30.00**	35.00	100.00	
Immediate Post Service-Time:	**7.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99243	**Recommended Physician Work RVU: 1.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**7.00**	**0.00**	**7.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.60	**RUC Time**	11,452,897

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99214	XXX	1.92	**RUC Time**	106,900,291

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 117 **% of respondents:** 50.0 **%**

Number of respondents who choose 2nd Key Reference Code: 43 **% of respondents:** 18.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 99243	Top Key Reference CPT Code: 99203	2nd Key Reference CPT Code: 99213
Median Pre-Service Time	7.00	5.00	5.00
Median Intra-Service Time	30.00	25.00	20.00
Median Immediate Post-service Time	7.00	5.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**44.00**	**35.00**	**30.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	3%	55%	41%	2%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	2%	62%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	1%	78%	21%
Physical effort required	3%	74%	24%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	58%	38%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	5%	53%	37%	5%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	51%	42%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	72%	23%
Physical effort required	5%	72%	23%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	60%	35%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background – Office Consultation Services (99242-99245)

CPT 2023 Changes

At the February 4-5, 2021 CPT virtual meeting, the following changes to the office consultation codes were approved:

- Deletion of code 99241
- Revision of codes 99242-99245 to align with changes to office/outpatient visit codes (99202-99215) including:
  - Requiring a medically appropriate history and/or examination
  - Allowing selection of level of service based on total time or medical decision making
- Recommendation to backfill code-level minimum time based on a RUC survey

Survey Process

AMA staff and the co-chairs of the CPT/RUC E/M Workgroup drafted a survey for the office consultation codes that was based on the 2019 office visit survey. This survey template was approved by the Research Subcommittee during a conference call on February 23, 2021. On this same call, the Research Subcommittee reviewed a list of potential reference codes to assist the surveying specialties with development of the office consultation survey RSL. On May 24, 2021, the Research Subcommittee reviewed and approved a request to modify the office consultation vignettes that were drafted by the CPT/RUC E/M Workgroup for the CPT code change application. Twenty-three societies surveyed the office consultation codes. Over 200 responses for physician work were received for each code.

Surveying Societies

AADA	American Academy of Dermatology Association
AAN	American Academy of Neurology
AANS	American Association of Neurological Surgeons
CNS	Congress of Neurological Surgeons
AAOS	American Academy of Orthopaedic Surgeons
AAP	American Academy of Pediatrics
AAHPM	American Academy of Hospice and Palliative Medicine
ACC	American College of Cardiology
ACG	American College of Gastroenterology
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ASGE	American Society for Gastrointestinal Endoscopy
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ACR	American College of Rheumatology
ACS	American College of Surgeons
ASCO	American Society of Clinical Oncology
ASCRS	American Society of Colon and Rectal Surgeons
ASSH	American Society for Surgery of the Hand
ACNM	American College of Nuclear Medicine
ATS	American Thoracic Society
ACCP	American College of Chest Physicians
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Although the recommended work RVUs for codes 99242-99245 are not greater than the current values, it is important to point out that the compelling evidence that supported the increased work RVUs for the office visit codes (99202-99215) also provides support for an increase in intensity of work for office consultation codes. This change in technology is described in the RUC database RUC rationale: "*According to National Medical Ambulatory Care Survey (NAMCS) data, in 2015, 76% of all practices used electronic health records exclusively, 11% used them partially, and 12% used only paper records. In 2008 the corresponding numbers were 29%, 17%, and 53%. All remarkable differences demonstrating that the technology used to deliver office-based care has changed dramatically. This is confirmed by the CDC, which estimates that use of an EHR increased from 35% in 2007 to 87% in 2015. The EHR contains more data than paper records, most of which must be reviewed including for drug-drug and, with increasing use of homeopathic substances, drug substance interactions. The use of EHRs has increased physician work by increasing the time*

physician spend documenting the medical record. In 2016, it was estimated that for every hour spent with patients, physicians spend 2 hours on EHR and desk work, according to an Annals of Internal Medicine study. With increased consolidation of hospitals and EHR systems (EPIC and Cerner now have a combined 85% market share of 500+ bed hospitals), physicians have access to more patient information. The centralization of data is in the best interest of patients and will help support quality care. However, this centralization does increase the time that physicians spend reviewing patient information. The presenters argued that EHR adoption has led to a decrease in efficiency, which may never be fully regained."

Office Consultation Work versus Office Visit Work

Office consultation codes are more work than the analogous office visit (non-consultation) E/M codes due to the additional work to generate and send a written report to the requesting physician/QHP that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient's problem(s). In addition, consultations carry more liability due to the expert opinion provided. Since the inception of the Medicare Physician Fee Schedule, the work RVUs for the office consultation codes have always been higher than the office visit E/M codes. The Harvard study acknowledged this difference in work.[1] The RUC acknowledged this difference in work in 2006.[2]

When CMS finalized policy to no longer recognize office consultation codes for payment, the Agency noted that: "*Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.*"[3]

The AMA responded to the Agency's change in policy noting that the CPT Editorial Panel was revising coding guidelines for consultation codes to reflect instructions in the CMS Carrier Policy Manual. CPT 2010 specifically added the following text: "*The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.*"

Although CMS no longer pays for consultation services, many private payors and patients continue to recognize the consultation codes for payment. The stakeholder societies that provide consultation services recognize the difference in physician work and liability related to documentation and expert opinion and continue to advocate for payment for these services.

Recommendation – 99243

We recommend a work RVU of 1.80, which is the survey median.

- The recommended work RVU of 1.80 is 0.20 work RVUs greater than 99203 to account for the additional work to generate and send a written report to the requesting physician/QHP that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient's problem(s).
- Codes 99243 and 99203 both include low complexity medical decision making.
- Code 99243 requires more total time than 99203.

Key Reference Code Comparison

Ref 1 99203: The respondents indicated the intensity/complexity of survey code 99243 is similar to somewhat more than reference code 99203.

Ref 2 99213: The respondents indicated the intensity/complexity of survey code 99243 is similar to somewhat more than reference code 99213.

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[1] Hsiao WC, et al. A National Study of Resource-Based Relative value Sales for Physician Services: Phase III Final Report. August 20, 1992. Volume 1. Table 7.8, pp 347-348.

[2] RUC Database 2006 RUC Rationale: The work of 99242 is also similar to 99203 New Office Visit, Level III. It was determined 99244 is more intense than 99205 and the recommended relativity appeared appropriate. 99245 is similar in total physician work to 99223 Initial Hospital Visit

[3] CMS MLN Matters Number MM6740. Related CR Release Date December 14, 2009. Related CR Transmittal # R1875CP

CPT	DESCRIPTOR	RVW	WPUT	TOTAL TIME	PRE	INTRA	POST
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	1.60	0.046	35	5	25	5
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	1.30	0.043	30	5	20	5
99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making	1.80	0.041	44	7	30	7

MPC Code Comparison

CPT	DESCRIPTOR	RVW	WPUT	TOTAL TIME	PRE	INTRA	POST
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	1.60	0.046	35	5	25	5
99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making	1.80	0.041	44	7	30	7
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	1.92	0.041	47	7	30	10

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99243

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty orthopedic surgery How often? Commonly

Specialty otolaryngology How often? Commonly

Specialty general surgery How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare currently does not pay for office visit consult codes. If CMS agrees to revise its policy, the last page of this SoR includes the 2009 utilization and specialty distribution as information

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Office visit

BETOS Sub-classification Level II:
New

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99243

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99243 (2009 Medicare utilization and specialty distribution)	4,973,944
ORTHOPEDIC SURGERY	13.33%
OTOLARYNGOLOGY	10.91%
GENERAL SURGERY	8.71%
GASTROENTEROLOGY	7.41%
UROLOGY	6.71%
INTERNAL MEDICINE	6.32%
OPHTHALMOLOGY	6.05%
CARDIOLOGY	5.65%
DERMATOLOGY	3.94%
FAMILY PRACTICE	3.40%
PODIATRY	2.38%
NEUROSURGERY	2.31%
NEUROLOGY	2.05%
PHYSICAL MEDICINE AND REHABILITATION	1.91%
PULMONARY DISEASE	1.58%
VASCULAR SURGERY	1.57%
PHYSICIANS ASSISTANT	1.47%
PLASTIC AND RECONSTRUCTIVE SURGERY	1.30%
NURSE PRACTITIONERS	1.12%
OBSTETRICS/GYNECOLOGY	1.00%
ANESTHESIOLOGY	0.92%
RADIATION ONCOLOGY	0.87%
RHEUMATOLOGY	0.85%
HAND SURGERY	0.78%
NEPHROLOGY	0.70%
ENDOCRINOLOGY	0.70%
COLORECTAL SURGERY(FORMERLY PROCTOLOGY)	0.67%
HEMATOLOGY/ONCOLOGY	0.61%
INTERVENTIONAL PAIN MANAGEMENT	0.49%
THORACIC SURGERY	0.45%
GENERAL PRACTICE	0.45%
ALLERGY/IMMUNOLOGY	0.44%
INFECTIOUS DISEASE	0.34%
OPTOMETRY	0.33%
CARDIAC SURGERY	0.31%
DIAGNOSTIC RADIOLOGY	0.29%
MEDICAL ONCOLOGY	0.23%
EMERGENCY MEDICINE	0.22%
PSYCHIATRY	0.19%
PAIN MANAGEMENT	0.16%
SURGICAL ONCOLOGY	0.11%
GERIATRIC MEDICINE	0.10%
CRITICAL CARE (INTENSIVISTS)	0.10%
ORAL SURGERY (DENTISTS ONLY)	0.08%
PEDIATRIC MEDICINE	0.07%
GYNECOLOGY/ONCOLOGY	0.06%
INTERVENTIONAL RADIOLOGY	0.06%

99243 (2009 Medicare utilization and specialty distribution)	**4,973,944**
PERIPHERAL VASCULAR DISEASE	0.06%
OSTEOPATHIC MANIPULATIVE THERAPY	0.05%
MAXILLOFACIAL SURGERY	0.05%
MULTISPECIALTY CLINIC OR GROUP PRACTICE	0.04%
HEMATOLOGY	0.04%
PATHOLOGY	0.03%
CERTIFIED CLINICAL NURSE SPECIALIST	0.02%
PREVENTIVE MEDICINE	0.01%
NUCLEAR MEDICINE	0.01%
NEUROPSYCHIATRY	0.01%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99244 Tracking Number G3 Original Specialty Recommended RVU: **2.80**
Presented Recommended RVU: **2.80**
Global Period: XXX Current Work RVU: **3.02** RUC Recommended RVU: **2.69**

CPT Descriptor: Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A requested office consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be an undiagnosed new problem with uncertain prognosis or chronic illness with progression. A report is generated and sent to the requesting provider.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Physician/QHP typical activities performed within 3 calendar days prior to the Office or Outpatient Consultation and within 7 calendar days after the day of the consultation include: Review the referring physician/QHP request for the consultant's expert opinion regarding evaluation and/or management of a specific medical problem. Document the request for the consultation in the medical record. Obtain and review prior medical records, including labs and imaging, if available. Order and review additional diagnostic labs, imaging and/or other tests, as needed. Incorporate pertinent information into the medical record. Review the medical history forms completed by the patient. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Perform a medically appropriate examination. Synthesize the relevant history, physical examination and tests to formulate a differential diagnosis requiring moderate level complexity MDM). Discuss the findings with the patient and family and respond to patient and family questions. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Generate and a written report that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient to the requesting provider. Document the report in the medical record. Communicate with other members of the health care team regarding the visit. Respond to follow-up questions from the requesting physician/QHP and patient/family.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Don Selzer, MD, FACS; Marianna Spanaki, MD, PhD; Phillip Rodgers, MD FAAHPM					
Specialty Society(ies):	AADA, AAN, AANS, CNS, AAOS, AAP, AAHPM, ACC, ACG, AGA, ASGE, ACOG, ACR, ACS, ASCO, ASCRS, ASSH, ACNM, ATS, ACCP, NASS, SNMMI, STS, AATS, SVS					
CPT Code:	99244					
Sample Size:	35232	**Resp N:**	248			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**20.00**	150.00	2500.00	
Survey RVW:	0.60	2.60	**2.80**	3.10	6.11	
Pre-Service Evaluation Time:			**10.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	5.00	30.00	**40.00**	46.00	200.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99244	**Recommended Physician Work RVU: 2.69**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.60	**RUC Time**	10,714,246

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.80	**RUC Time**	10,388,878

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 143 **% of respondents:** 57.6 **%**

Number of respondents who choose 2nd Key Reference Code: 49 **% of respondents:** 19.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 99244	Top Key Reference CPT Code: 99204	2nd Key Reference CPT Code: **99214**
Median Pre-Service Time	10.00	10.00	7.00
Median Intra-Service Time	40.00	40.00	30.00
Median Immediate Post-service Time	10.00	10.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**60.00**	**60.00**	**47.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	6%	34%	52%	11%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	47%	50%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	1%	66%	34%
Physical effort required	1%	68%	31%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	38%	59%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	27%	59%	10%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	2%	45%	53%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	59%	37%
Physical effort required	4%	57%	39%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	31%	63%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background – Office Consultation Services (99242-99245)

CPT 2023 Changes

At the February 4-5, 2021 CPT virtual meeting, the following changes to the office consultation codes were approved:

- Deletion of code 99241
- Revision of codes 99242-99245 to align with changes to office/outpatient visit codes (99202-99215) including:
  - Requiring a medically appropriate history and/or examination
  - Allowing selection of level of service based on total time or medical decision making
- Recommendation to backfill code-level minimum time based on a RUC survey

Survey Process

AMA staff and the co-chairs of the CPT/RUC E/M Workgroup drafted a survey for the office consultation codes that was based on the 2019 office visit survey. This survey template was approved by the Research Subcommittee during a conference call on February 23, 2021. On this same call, the Research Subcommittee reviewed a list of potential reference codes to assist the surveying specialties with development of the office consultation survey RSL. On May 24, 2021, the Research Subcommittee reviewed and approved a request to modify the office consultation vignettes that were drafted by the CPT/RUC E/M Workgroup for the CPT code change application. Twenty-three societies surveyed the office consultation codes. Over 200 responses for physician work were received for each code.

Surveying Societies

AADA	American Academy of Dermatology Association
AAN	American Academy of Neurology
AANS	American Association of Neurological Surgeons
CNS	Congress of Neurological Surgeons
AAOS	American Academy of Orthopaedic Surgeons
AAP	American Academy of Pediatrics
AAHPM	American Academy of Hospice and Palliative Medicine
ACC	American College of Cardiology
ACG	American College of Gastroenterology
AGA	American Gastroenterological Association
ASGE	American Society for Gastrointestinal Endoscopy
ACOG	American College of Obstetricians and Gynecologists
ACR	American College of Rheumatology
ACS	American College of Surgeons
ASCO	American Society of Clinical Oncology
ASCRS	American Society of Colon and Rectal Surgeons
ASSH	American Society for Surgery of the Hand
ACNM	American College of Nuclear Medicine
ATS	American Thoracic Society
ACCP	American College of Chest Physicians
NASS	North American Spine Society
SNMMI	Society of Nuclear Medicine and Molecular Imaging
STS	Society of Thoracic Surgeons
AATS	American Association for Thoracic Surgery
SVS	Society for Vascular Surgery

Change in Technology

Although the recommended work RVUs for codes 99242-99245 are not greater than the current values, it is important to point out that the compelling evidence that supported the increased work RVUs for the office visit codes (99202-99215) also provides support for an increase in intensity of work for office consultation codes. This change in technology is described in the RUC database RUC rationale: "*According to National Medical Ambulatory Care Survey (NAMCS) data, in 2015, 76% of all practices used electronic health records exclusively, 11% used them partially, and 12% used only paper records. In 2008 the corresponding numbers were 29%, 17%, and 53%. All remarkable differences demonstrating that the technology used to deliver office-based care has changed dramatically. This is confirmed by the CDC, which estimates that use of an EHR increased from 35% in 2007 to 87% in 2015. The EHR contains more data than paper records, most of which must be reviewed including for drug-drug and, with increasing use of homeopathic substances, drug substance interactions. The use of EHRs has increased physician work by increasing the time physician spend documenting the medical record. In 2016, it was estimated that for every hour spent with patients, physicians spend 2 hours on EHR and desk work, according to an Annals of Internal Medicine study. With increased*

consolidation of hospitals and EHR systems (EPIC and Cerner now have a combined 85% market share of 500+ bed hospitals), physicians have access to more patient information. The centralization of data is in the best interest of patients and will help support quality care. However, this centralization does increase the time that physicians spend reviewing patient information. The presenters argued that EHR adoption has led to a decrease in efficiency, which may never be fully regained."

Office Consultation Work versus Office Visit Work

Office consultation codes are more work than the analogous office visit (non-consultation) E/M codes due to the additional work to generate and send a written report to the requesting physician/QHP that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient's problem(s). In addition, consultations carry more liability due to the expert opinion provided. Since the inception of the Medicare Physician Fee Schedule, the work RVUs for the office consultation codes have always been higher than the office visit E/M codes. The Harvard study acknowledged this difference in work.[1] The RUC acknowledged this difference in work in 2006.[2]

When CMS finalized policy to no longer recognize office consultation codes for payment, the Agency noted that: "*Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.*"[3]

The AMA responded to the Agency's change in policy noting that the CPT Editorial Panel was revising coding guidelines for consultation codes to reflect instructions in the CMS Carrier Policy Manual. CPT 2010 specifically added the following text: "*The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.*"

Although CMS no longer pays for consultation services, many private payors and patients continue to recognize the consultation codes for payment. The stakeholder societies that provide consultation services recognize the difference in physician work and liability related to documentation and expert opinion and continue to advocate for payment for these services.

Recommendation – 99244

We recommend a work RVU of 2.80, which is the survey median.

- The recommended work RVU of 2.80 is 0.20 work RVUs greater than 99204 to account for the additional intensity of work to generate and send a written report to the requesting physician/QHP that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient's problem(s).
- Codes 99244 and 99204 both include moderate complexity medical decision making.

Key Reference Code Comparison

Ref 1 99204: The respondents indicated the intensity/complexity of survey code 99244 is somewhat to much more than reference code 99204.

Ref 2 99214: The respondents indicated the intensity/complexity of survey code 99244 is similar to somewhat to much more than reference code 99214.

CPT	DESCRIPTOR	RVW	WPUT	TOTAL TIME	PRE	INTRA	POST
99204	Office or other outpatient visit for the evaluation and management	**2.60**	**0.043**	**60**	**10**	**40**	**10**

[1] Hsiao WC, et al. A National Study of Resource-Based Relative value Sales for Physician Services: Phase III Final Report. August 20, 1992. Volume 1. Table 7.8, pp 347-348.

[2] RUC Database 2006 RUC Rationale: The work of 99242 is also similar to 99203 New Office Visit, Level III. It was determined 99244 is more intense than 99205 and the recommended relativity appeared appropriate. 99245 is similar in total physician work to 99223 Initial Hospital Visit

[3] CMS MLN Matters Number MM6740. Related CR Release Date December 14, 2009. Related CR Transmittal # R1875CP

	of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.						
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	**1.92**	**0.041**	**47**	**7**	**30**	**10**
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making	**2.80**	**0.047**	**60**	**10**	**40**	**10**

MPC Code Comparison

CPT	DESCRIPTOR	RVW	WPUT	TOTAL TIME	PRE	INTRA	POST
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	**2.60**	**0.043**	**60**	**10**	**40**	**10**
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making	**2.80**	**0.047**	**60**	**10**	**40**	**10**
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	**2.80**	**0.040**	**70**	**10**	**45**	**15**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99244

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty ophthalmology How often? Commonly

Specialty neurology How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare currently does not pay for office visit consult codes. If CMS agrees to revise its policy, the last page of this SoR includes the 2009 utilization and specialty distribution as information

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Office visit

BETOS Sub-classification Level II:
New

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99244

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99243 (2009 Medicare utilization and specialty distribution)	**6,311,520**
CARDIOLOGY	13.24%

99243 (2009 Medicare utilization and specialty distribution)	6,311,520
OPHTHALMOLOGY	10.09%
NEUROLOGY	8.09%
GASTROENTEROLOGY	7.93%
INTERNAL MEDICINE	7.56%
UROLOGY	6.15%
GENERAL SURGERY	5.17%
ORTHOPEDIC SURGERY	4.66%
PULMONARY DISEASE	4.48%
OTOLARYNGOLOGY	3.44%
RHEUMATOLOGY	2.35%
ENDOCRINOLOGY	2.15%
NEPHROLOGY	2.11%
HEMATOLOGY/ONCOLOGY	2.05%
PHYSICAL MEDICINE AND REHABILITATION	2.03%
FAMILY PRACTICE	1.99%
NEUROSURGERY	1.98%
RADIATION ONCOLOGY	1.87%
VASCULAR SURGERY	1.31%
NURSE PRACTITIONERS	1.07%
ANESTHESIOLOGY	0.94%
PHYSICIANS ASSISTANT	0.90%
OBSTETRICS/GYNECOLOGY	0.86%
INTERVENTIONAL PAIN MANAGEMENT	0.74%
MEDICAL ONCOLOGY	0.67%
ALLERGY/IMMUNOLOGY	0.62%
THORACIC SURGERY	0.54%
INFECTIOUS DISEASE	0.51%
PLASTIC AND RECONSTRUCTIVE SURGERY	0.44%
OPTOMETRY	0.39%
CARDIAC SURGERY	0.38%
GENERAL PRACTICE	0.32%
COLORECTAL SURGERY(FORMERLY PROCTOLOGY)	0.32%
PSYCHIATRY	0.29%
CRITICAL CARE (INTENSIVISTS)	0.28%
DERMATOLOGY	0.25%
EMERGENCY MEDICINE	0.22%
PAIN MANAGEMENT	0.22%
DIAGNOSTIC RADIOLOGY	0.19%
GYNECOLOGY/ONCOLOGY	0.15%
PODIATRY	0.14%
HEMATOLOGY	0.14%
SURGICAL ONCOLOGY	0.14%
HAND SURGERY	0.11%
GERIATRIC MEDICINE	0.10%
PEDIATRIC MEDICINE	0.08%
OSTEOPATHIC MANIPULATIVE THERAPY	0.05%
PERIPHERAL VASCULAR DISEASE	0.05%
ORAL SURGERY (DENTISTS ONLY)	0.05%
INTERVENTIONAL RADIOLOGY	0.04%

99243 (2009 Medicare utilization and specialty distribution)	**6,311,520**
MULTISPECIALTY CLINIC OR GROUP PRACTICE	0.04%
CERTIFIED CLINICAL NURSE SPECIALIST	0.02%
NEUROPSYCHIATRY	0.02%
PATHOLOGY	0.02%
MAXILLOFACIAL SURGERY	0.02%
PREVENTIVE MEDICINE	0.01%
UNKNOWN PHYSICIAN SPECIALTY	0.01%
NUCLEAR MEDICINE	0.01%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99245 Tracking Number G4 Original Specialty Recommended RVU: **3.75**
Presented Recommended RVU: **3.75**
Global Period: XXX Current Work RVU: **3.77** RUC Recommended RVU: **3.75**

CPT Descriptor: Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A requested office consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be a chronic illness with severe exacerbation, progression or side effects of treatment. A report is generated and sent to the requesting provider.

Percentage of Survey Respondents who found Vignette to be Typical: 91%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work:

Description of Intra-Service Work: Physician/QHP typical activities performed within 3 calendar days prior to the Office or Outpatient Consultation and within 7 calendar days after the day of the consultation include: Review the referring physician/QHP request for the consultant's expert opinion regarding evaluation and/or management of a specific medical problem. Document the request for the consultation in the medical record. Obtain and review prior medical records, including labs and imaging, if available. Order and review additional diagnostic labs, imaging and/or other tests, as needed. Incorporate pertinent information into the medical record. Review the medical history forms completed by the patient. Review vital signs obtained by clinical staff. Obtain a medically appropriate history. Perform a medically appropriate examination. Synthesize the relevant history, physical examination and tests to formulate a differential diagnosis requiring high level complexity MDM. Discuss the findings with the patient and family and respond to patient and family questions. Document the encounter in the medical record. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Generate and a written report that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient to the requesting provider. Document the report in the medical record. Communicate with other members of the health care team regarding the visit. Respond to follow-up questions from the requesting physician/QHP and patient/family.

Description of Post-Service Work:

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Richard Wright, MD; Don Selzer, MD, FACS; Marianna Spanaki, MD, PhD; Phillip Rodgers, MD FAAHPM					
Specialty Society(ies):	AADA, AAN, AANS, CNS, AAOS, AAP, AAHPM, ACC, ACG, AGA, ASGE, ACOG, ACR, ACS, ASCO, ASCRS, ASSH, ACNM, ATS, ACCP, NASS, SNMMI, STS, AATS, SVS					
CPT Code:	99245					
Sample Size:	35232	**Resp N:**	231			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	1.00	**15.00**	68.00	1000.00	
Survey RVW:	1.00	3.50	**3.75**	4.00	7.22	
Pre-Service Evaluation Time:			**15.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	5.00	40.00	**55.00**	60.00	300.00	
Immediate Post Service-Time:	**17.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99245	**Recommended Physician Work RVU: 3.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**55.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**17.00**	**0.00**	**17.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.50	**RUC Time**	2,923,626

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99291	XXX	4.50	**RUC Time**	5,905,780

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 158 **% of respondents:** 68.3 **%**

Number of respondents who choose 2nd Key Reference Code: 43 **% of respondents:** 18.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99245	Top Key Reference CPT Code: 99205	2nd Key Reference CPT Code: 99215
Median Pre-Service Time	15.00	14.00	10.00
Median Intra-Service Time	55.00	59.00	45.00
Median Immediate Post-service Time	17.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**87.00**	**88.00**	**70.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	1%	1%	30%	37%	30%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	39%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	1%	53%	46%

Physical effort required	2%	58%	40%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	33%	62%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	23%	42%	35%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	37%	63%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	2%	58%	40%
Physical effort required	2%	56%	42%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	30%	67%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background – Office Consultation Services (99242-99245)

CPT 2023 Changes

At the February 4-5, 2021 CPT virtual meeting, the following changes to the office consultation codes were approved:

- Deletion of code 99241

- Revision of codes 99242-99245 to align with changes to office/outpatient visit codes (99202-99215) including:
  - Requiring a medically appropriate history and/or examination
  - Allowing selection of level of service based on total time or medical decision making
- Recommendation to backfill code-level minimum time based on a RUC survey

Survey Process

AMA staff and the co-chairs of the CPT/RUC E/M Workgroup drafted a survey for the office consultation codes that was based on the 2019 office visit survey. This survey template was approved by the Research Subcommittee during a conference call on February 23, 2021. On this same call, the Research Subcommittee reviewed a list of potential reference codes to assist the surveying specialties with development of the office consultation survey RSL. On May 24, 2021, the Research Subcommittee reviewed and approved a request to modify the office consultation vignettes that were drafted by the CPT/RUC E/M Workgroup for the CPT code change application. Twenty-three societies surveyed the office consultation codes. Over 200 responses for physician work were received for each code.

Surveying Societies

AADA	American Academy of Dermatology Association
AAN	American Academy of Neurology
AANS	American Association of Neurological Surgeons
CNS	Congress of Neurological Surgeons
AAOS	American Academy of Orthopaedic Surgeons
AAP	American Academy of Pediatrics
AAHPM	American Academy of Hospice and Palliative Medicine
ACC	American College of Cardiology
ACG	American College of Gastroenterology
AGA	American Gastroenterological Association
ASGE	American Society for Gastrointestinal Endoscopy
ACOG	American College of Obstetricians and Gynecologists
ACR	American College of Rheumatology
ACS	American College of Surgeons
ASCO	American Society of Clinical Oncology
ASCRS	American Society of Colon and Rectal Surgeons
ASSH	American Society for Surgery of the Hand
ACNM	American College of Nuclear Medicine
ATS	American Thoracic Society
ACCP	American College of Chest Physicians
NASS	North American Spine Society
SNMMI	Society of Nuclear Medicine and Molecular Imaging
STS	Society of Thoracic Surgeons
AATS	American Association for Thoracic Surgery
SVS	Society for Vascular Surgery

Change in Technology

Although the recommended work RVUs for codes 99242-99245 are not greater than the current values, it is important to point out that the compelling evidence that supported the increased work RVUs for the office visit codes (99202-99215) also provides support for an increase in intensity of work for office consultation codes. This change in technology is described in the RUC database RUC rationale: "*According to National Medical Ambulatory Care Survey (NAMCS) data, in 2015, 76% of all practices used electronic health records exclusively, 11% used them partially, and 12% used only paper records. In 2008 the corresponding numbers were 29%, 17%, and 53%. All remarkable differences demonstrating that the technology used to deliver office-based care has changed dramatically. This is confirmed by the CDC, which estimates that use of an EHR increased from 35% in 2007 to 87% in 2015. The EHR contains more data than paper records, most of which must be reviewed including for drug-drug and, with increasing use of homeopathic substances, drug substance interactions. The use of EHRs has increased physician work by increasing the time physician spend documenting the medical record. In 2016, it was estimated that for every hour spent with patients, physicians spend 2 hours on EHR and desk work, according to an Annals of Internal Medicine study. With increased consolidation of hospitals and EHR systems (EPIC and Cerner now have a combined 85% market share of 500+ bed hospitals), physicians have access to more patient information. The centralization of data is in the best interest of patients and will help support quality care. However, this centralization does increase the time that physicians spend*

reviewing patient information. The presenters argued that EHR adoption has led to a decrease in efficiency, which may never be fully regained."

Office Consultation Work versus Office Visit Work

Office consultation codes are more work than the analogous office visit (non-consultation) E/M codes due to the additional work to generate and send a written report to the requesting physician/QHP that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient's problem(s). In addition, consultations carry more liability due to the expert opinion provided. Since the inception of the Medicare Physician Fee Schedule, the work RVUs for the office consultation codes have always been higher than the office visit E/M codes. The Harvard study acknowledged this difference in work.[1] The RUC acknowledged this difference in work in 2006.[2]

When CMS finalized policy to no longer recognize office consultation codes for payment, the Agency noted that: "*Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.*"[3]

The AMA responded to the Agency's change in policy noting that the CPT Editorial Panel was revising coding guidelines for consultation codes to reflect instructions in the CMS Carrier Policy Manual. CPT 2010 specifically added the following text: "*The written or verbal request for consult may be made by a physician or other appropriate source and documented in the patient's medical record by either the consulting or requesting physician or appropriate source. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting physician or other appropriate source.*"

Although CMS no longer pays for consultation services, many private payors and patients continue to recognize the consultation codes for payment. The stakeholder societies that provide consultation services recognize the difference in physician work and liability related to documentation and expert opinion and continue to advocate for payment for these services.

Recommendation – 99245

We recommend a work RVU of 3.75, which is the survey median.

- The recommended work RVU of 3.75 is 0.25 work RVUs greater than 99205 to account for the additional intensity of work to generate and send a written report to the requesting physician/QHP that identifies additional labs, imaging and/or tests ordered and reviewed, test findings and expert opinion for management of the patient's problem(s).
- Codes 99245 and 99205 both include high complexity medical decision making.

Key Reference Code Comparison

Ref 1 99205: The respondents indicated the intensity/complexity of survey code 99245 is somewhat to much more than reference code 99205.

Ref 2 99215: The respondents indicated the intensity/complexity of survey code 99245 is similar to somewhat to much more than reference code 99215.

CPT	DESCRIPTOR	RVW	WPUT	TOTAL TIME	PRE	INTRA	POST
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	**3.50**	**0.040**	**88**	**14**	**59**	**15**

[1] Hsiao WC, et al. A National Study of Resource-Based Relative value Sales for Physician Services: Phase III Final Report. August 20, 1992. Volume 1. Table 7.8, pp 347-348.

[2] RUC Database 2006 RUC Rationale: The work of 99242 is also similar to 99203 New Office Visit, Level III. It was determined 99244 is more intense than 99205 and the recommended relativity appeared appropriate. 99245 is similar in total physician work to 99223 Initial Hospital Visit

[3] CMS MLN Matters Number MM6740. Related CR Release Date December 14, 2009. Related CR Transmittal # R1875CP

99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	**2.80**	**0.040**	**70**	**10**	**45**	**15**
99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making	**3.75**	**0.043**	**87**	**15**	**55**	**17**

MPC Code Comparison

CPT	DESCRIPTOR	RVW	WPUT	TOTAL TIME	PRE	INTRA	POST
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	**3.50**	**0.040**	**88**	**14**	**59**	**15**
99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making	**3.75**	**0.043**	**87**	**15**	**55**	**17**
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	**4.50**	**0.064**	**70**	**15**	**40**	**15**

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99245

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty cardiology How often? Commonly

Specialty neurology How often? Commonly

Specialty internal medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National utilization data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 0 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Medicare currently does not pay for office visit consult codes. If CMS agrees to revise its policy, the last page of this SoR includes the 2009 utilization and specialty distribution as information

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Do many physicians perform this service across the United States? Yes

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Office visit

BETOS Sub-classification Level II:
New

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99245

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99245 (2009 Medicare utilization and specialty distribution)	**2,235,263**
CARDIOLOGY	14.48%
NEUROLOGY	14.13%
INTERNAL MEDICINE	8.72%
HEMATOLOGY/ONCOLOGY	8.16%
PULMONARY DISEASE	6.17%
GENERAL SURGERY	4.22%
RADIATION ONCOLOGY	4.06%

99245 (2009 Medicare utilization and specialty distribution)	2,235,263
GASTROENTEROLOGY	3.65%
NEPHROLOGY	3.12%
RHEUMATOLOGY	2.78%
ENDOCRINOLOGY	2.73%
MEDICAL ONCOLOGY	2.65%
UROLOGY	2.57%
OPHTHALMOLOGY	2.41%
NEUROSURGERY	2.12%
ORTHOPEDIC SURGERY	2.02%
THORACIC SURGERY	1.37%
FAMILY PRACTICE	1.25%
CARDIAC SURGERY	1.20%
PHYSICAL MEDICINE AND REHABILITATION	1.10%
VASCULAR SURGERY	1.05%
OTOLARYNGOLOGY	1.02%
OBSTETRICS/GYNECOLOGY	0.83%
INFECTIOUS DISEASE	0.79%
GYNECOLOGY/ONCOLOGY	0.65%
NURSE PRACTITIONERS	0.63%
PSYCHIATRY	0.60%
ANESTHESIOLOGY	0.57%
HEMATOLOGY	0.57%
PHYSICIANS ASSISTANT	0.44%
INTERVENTIONAL PAIN MANAGEMENT	0.40%
CRITICAL CARE (INTENSIVISTS)	0.38%
ALLERGY/IMMUNOLOGY	0.37%
PLASTIC AND RECONSTRUCTIVE SURGERY	0.33%
SURGICAL ONCOLOGY	0.32%
EMERGENCY MEDICINE	0.30%
GENERAL PRACTICE	0.29%
DIAGNOSTIC RADIOLOGY	0.28%
COLORECTAL SURGERY(FORMERLY PROCTOLOGY)	0.26%
GERIATRIC MEDICINE	0.24%
PAIN MANAGEMENT	0.14%
OPTOMETRY	0.09%
PEDIATRIC MEDICINE	0.08%
ORAL SURGERY (DENTISTS ONLY)	0.06%
DERMATOLOGY	0.06%
PERIPHERAL VASCULAR DISEASE	0.05%
OSTEOPATHIC MANIPULATIVE THERAPY	0.04%
NEUROPSYCHIATRY	0.04%
HAND SURGERY	0.04%
MULTISPECIALTY CLINIC OR GROUP PRACTICE	0.03%
INTERVENTIONAL RADIOLOGY	0.03%
MAXILLOFACIAL SURGERY	0.02%
PODIATRY	0.02%
CERTIFIED CLINICAL NURSE SPECIALIST	0.02%
PATHOLOGY	0.01%
UNKNOWN PHYSICIAN SPECIALTY	0.01%

99245 (2009 Medicare utilization and specialty distribution)	**2,235,263**
PREVENTIVE MEDICINE	0.01%
NUCLEAR MEDICINE	0.01%
RADIATION THERAPY CENTERS	0.01%

ISSUE: Consultations
TAB: 11

SOURCE	Review Year	CPT	DESC	Glob	Resp	MDM	CPT Time	IWPUT	WPUT	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	POST	12 Month Svy Experience MIN	12 Month Svy Experience 25th	12 Month Svy Experience MED	12 Month Svy Experience 75th	12 Month Svy Experience MAX	% Typ	2009 Util	2019 Util
REF1	**2019**	**99202**	Office or other outpatient visit for the evaluation an	**XXX**	109	**SF**	**15-29**	**0.047**	**0.047**			**0.93**			**20**	2			**15**			3							**2,352,028**	**2,490,658**
REF2	**2019**	**99212**	Office or other outpatient visit for the evaluation an	**XXX**	36	**SF**	**10-19**	**0.044**	**0.044**			**0.70**			**16**	2			**11**			3							**19,660,130**	**10,729,531**
Current	**2006**	**99241**	Office consultation for a new or established patient	**XXX**		**SF**	**15 F2F**	**0.028**	**0.026**			**0.64**			**25**	5			**15**			5							**283,653**	**n/a**
Current	**2006**	**99242**	Office consultation for a new or established patient	**XXX**		**SF**	**30 F2F**	**0.040**	**0.034**			**1.34**			**40**	5			**25**			10							**1,378,035**	**n/a**
SVY		**99242**	Office or other outpatient consultation for a ne	**XXX**	**213**	**SF**		**0.043**	**0.036**	**0.18**	**0.93**	**1.08**	**1.49**	**3.85**	**30**	**5**	**2**	**15**	**20**	**25**	**45**	**5**	**0**	**0**	**5**	**20**	**750**	**91%**		
REC		**99242**	**Office or other outpatient consultation for a new**	**XXX**		**SF**		**0.043**	**0.036**			**1.08**			**30**	**5**			**20**			**5**								
Medicine		*99242*	*REF1 = 99202*	*XXX*	*100*			*0.044*	*0.037*	*0.20*	*0.93*	*1.10*	*1.50*	*3.50*	*30*	*5*	*2*	*12*	*20*	*25*	*45*	*5*	*0*	*0*	*5*	*20*	*500*	*90%*		
Surgery		*99242*	*REF1 = 99202*	*XXX*	*107*			*0.044*	*0.038*	*0.20*	*0.97*	*1.05*	*1.45*	*3.85*	*28*	*3*	*2*	*15*	*20*	*25*	*35*	*5*	*0*	*0*	*3*	*20*	*750*	*91%*		
PCP		*99242*	*REF1 = 99202*	*XXX*	*6*			*0.074*	*0.043*	*0.18*	*0.96*	*1.08*	*1.23*	*1.40*	*25*	*5*	*6*	*10*	*10*	*14*	*25*	*10*	*0*	*1*	*2*	*4*	*10*	*100%*		
REF1	**2019**	**99203**	Office or other outpatient visit for the evaluation an	**XXX**	117	**LOW**	**30-44**	**0.046**	**0.046**			**1.60**			**35**	5			**25**			5							**5,468,748**	**11,452,897**
REF2	**2019**	**99213**	Office or other outpatient visit for the evaluation an	**XXX**	43	**LOW**	**20-29**	**0.043**	**0.043**			**1.30**			**30**	5			**20**			5							**101,611,504**	**92,217,549**
Current	**2006**	**99243**	Office consultation for a new or established patient	**XXX**		**LOW**	**40 F2F**	**0.062**	**0.047**			**1.88**			**40**	5			**25**			10							**4,973,944**	**n/a**
SVY		**99243**	Office or other outpatient consultation for a ne	**XXX**	**234**	**LOW**		**0.050**	**0.041**	**0.40**	**1.60**	**1.80**	**2.00**	**38.00**	**44**	**7**	**3**	**20**	**30**	**35**	**100**	**7**	**0**	**2**	**20**	**100**	**3000**	**90%**		
REC		**99243**	**Office or other outpatient consultation for a new**	**XXX**		**LOW**		**0.050**	**0.041**			**1.80**			**44**	**7**			**30**			**7**								
Medicine		*99243*	*REF1 = 99203*	*XXX*	*114*			*0.049*	*0.040*	*0.70*	*1.60*	*1.80*	*2.00*	*4.00*	*45*	*8*	*5*	*20*	*30*	*35*	*100*	*7*	*0*	*4*	*20*	*100*	*3000*	*84%*		
Surgery		*99243*	*REF1 = 99203*	*XXX*	*113*			*0.051*	*0.043*	*0.40*	*1.60*	*1.80*	*2.10*	*38.00*	*42*	*5*	*3*	*20*	*30*	*35*	*64*	*7*	*0*	*3*	*25*	*93*	*1300*	*95%*		
PCP		*99243*	*REF1 = 99203*	*XXX*	*7*			*0.060*	*0.041*	*1.30*	*1.40*	*1.65*	*1.78*	*2.00*	*40*	*10*	*14*	*18*	*20*	*28*	*35*	*10*	*0*	*1*	*2*	*10*	*50*	*100%*		
REF1	**2019**	**99204**	Office or other outpatient visit for the evaluation an	**XXX**	143	**MOD**	**45-59**	**0.043**	**0.043**			**2.60**			**60**	10			**40**			10							**3,426,345**	**10,714,246**
REF2	**2019**	**99214**	Office or other outpatient visit for the evaluation an	**XXX**	49	**MOD**	**30-39**	**0.041**	**0.041**			**1.92**			**47**	7			**30**			10							**72,747,648**	**106,900,291**
Current	**2006**	**99244**	Office consultation for a new or established patient	**XXX**		**MOD**	**60 F2F**	**0.062**	**0.046**			**3.02**			**65**	10			**40**			15							**6,311,520**	**n/a**
SVY		**99244**	Office or other outpatient consultation for a ne	**XXX**	**248**	**MOD**		**0.059**	**0.047**	**0.60**	**2.60**	**2.80**	**3.10**	**6.11**	**60**	**10**	**5**	**30**	**40**	**46**	**200**	**10**	**0**	**5**	**30**	**150**	**2500**	**94%**		
REC		**99244**	**Office or other outpatient consultation for a new**	**XXX**		**MOD**		**0.056**	**0.045**			**2.69**			**60**	**10**			**40**			**10**								
Medicine		*99244*	*REF1 = 99204*	*XXX*	*129*			*0.058*	*0.045*	*0.80*	*2.50*	*2.80*	*3.08*	*4.80*	*62*	*12*	*5*	*30*	*40*	*48*	*200*	*10*	*0*	*10*	*50*	*200*	*2500*	*95%*		
Surgery		*99244*	*REF1 = 99204*	*XXX*	*112*			*0.059*	*0.047*	*0.60*	*2.60*	*2.85*	*3.20*	*6.11*	*61*	*10*	*6*	*30*	*40*	*45*	*90*	*11*	*0*	*2*	*27*	*104*	*1880*	*92%*		
PCP		*99244*	*REF1 = 99204*	*XXX*	*7*			*0.065*	*0.044*	*1.46*	*2.02*	*2.63*	*2.71*	*2.80*	*60*	*15*	*20*	*25*	*30*	*40*	*50*	*15*	*0*	*1*	*4*	*12*	*410*	*100%*		
Crosswalk		**93315**	Transesophageal echocardiography for congenital	**XXX**				**0.053**	**0.041**			**2.69**			**65**	10			**40**			15								
REF1	**2019**	**99205**	Office or other outpatient visit for the evaluation an	**XXX**	158	**HIGH**	**60-74**	**0.040**	**0.040**			**3.50**			**88**	14			**59**			15							**1,018,170**	**2,923,626**
REF2	**2019**	**99215**	Office or other outpatient visit for the evaluation an	**XXX**	43	**HIGH**	**40-54**	**0.040**	**0.040**			**2.80**			**70**	10			**45**			15							**8,828,743**	**10,388,878**
Current		**99245**	Office consultation for a new or established patient	**XXX**		**HIGH**	**80 F2F**	**0.052**	**0.042**			**3.77**			**90**	10			**60**			20							**2,235,263**	**n/a**
SVY		**99245**	Office or other outpatient consultation for a ne	**XXX**	**231**	**HIGH**		**0.055**	**0.043**	**1.00**	**3.50**	**3.75**	**4.00**	**7.22**	**87**	**15**	**5**	**40**	**55**	**60**	**300**	**17**	**0**	**1**	**15**	**68**	**1000**	**91%**		
REC		**99245**	**Office or other outpatient consultation for a new**	**XXX**		**HIGH**		**0.055**	**0.043**			**3.75**			**87**	**15**			**55**			**17**								
Medicine		*99245*	*REF1 = 99205*	*XXX*	*126*			*0.048*	*0.038*	*1.10*	*3.50*	*3.75*	*4.00*	*5.08*	*98*	*20*	*5*	*40*	*60*	*60*	*300*	*18*	*0*	*5*	*25*	*100*	*1000*	*93%*		
Surgery		*99245*	*REF1 = 99205*	*XXX*	*98*			*0.059*	*0.046*	*1.00*	*3.50*	*3.80*	*4.00*	*7.22*	*83*	*15*	*10*	*41*	*53*	*60*	*120*	*15*	*0*	*0*	*7*	*32*	*285*	*89%*		
PCP		*99245*	*REF1 = 99205*	*XXX*	*7*			*0.058*	*0.040*	*1.60*	*2.90*	*3.60*	*3.80*	*4.50*	*89*	*24*	*25*	*33*	*45*	*53*	*65*	*20*	*0*	*0*	*0*	*6*	*100*	*86%*		

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99242, 99243, 99244, 99245
SPECIALTY SOCIETY(IES): AADA, AAN, AANS, CNS, AAOS, AAP, AAHPM, ACC, ACG, AGA, ASGE, ACOG, ACR, ACS, ASCO, ASCRS, ASSH, ACNM, ATS, ACCP, NASS, SNMMI, STS, AATS, SVS
PRESENTER(S): Matthew Sideman, MD; Stephen Sentovich, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
99242	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.	XXX
99243	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.	XXX
99244	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.	XXX
99245	Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99242	A requested office consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be self-limited. A report is generated and sent to the requesting provider.
99243	A requested office consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to an acute uncomplicated illness or injury. A report is generated and sent to the requesting provider.
99244	A requested office consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be an undiagnosed new problem with uncertain prognosis or chronic illness with progression. A report is generated and sent to the requesting provider.
99245	A requested office consultation, which includes review of the relevant data and a medically appropriate history and/or examination, is performed. The problem is determined to be a chronic illness with severe exacerbation, progression or side effects of treatment. A report is generated and sent to the requesting provider.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

Twenty-five societies surveyed for practice expense data via the approved practice expense tool for E/M surveys:
American Academy of Dermatology Association
American Academy of Neurology
American Association of Neurological Surgeons
Congress of Neurological Surgeons
American Academy of Orthopaedic Surgeons
American Academy of Pediatrics
American Academy of Hospice and Palliative Medicine
American College of Cardiology
American College of Gastroenterology

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99242, 99243, 99244, 99245
SPECIALTY SOCIETY(IES): AADA, AAN, AANS, CNS, AAOS, AAP, AAHPM, ACC, ACG, AGA, ASGE, ACOG, ACR, ACS, ASCO, ASCRS, ASSH, ACNM, ATS, ACCP, NASS, SNMMI, STS, AATS, SVS
PRESENTER(S): Matthew Sideman, MD; Stephen Sentovich, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

American Gastroenterological Association
American Society for Gastrointestinal Endoscopy
American College of Obstetricians and Gynecologists
American College of Rheumatology
American College of Surgeons
American Society of Clinical Oncology
American Society of Colon and Rectal Surgeons
American Society for Surgery of the Hand
American College of Nuclear Medicine
American Thoracic Society
American College of Chest Physicians
North American Spine Society
Society of Nuclear Medicine and Molecular Imaging
Society of Thoracic Surgeons
American Association for Thoracic Surgery
Society for Vascular Surgery

To develop the clinical staff time recommendations, the expert panel followed the process approved by the PE Subcommittee and the RUC in 2019 for the office/outpatient visit codes (see excepted text at the end of this document).

A RUC survey was conducted that included questions about clinical staff times. The same survey questions used for the office visit PE survey were used for the current survey. Respondents were asked to indicate the typical clinical staff time spent for several specific activities. Survey respondents were also allowed to recommend times for "other clinical activity" in all three service-periods (pre service, service period, post service) and include comments.

The society expert panel reviewed the median survey total times in developing the practice expense recommendations. It was acknowledged there is variation among specialties in how they perform consult services; specifically, how a specialty's clinical staff performs some or all of the activities. As such, it made the most sense to use the median survey total time vs. the median of the individual task time as the basis for the recommendation. This is exactly how the clinical staff time recommendations were developed for the office visit codes—based on many conference calls and final PE Subcommittee approval.

Guiding Principals
The specialty societies used the survey median total time as the guiding principal for the recommended times. The consensus panel also took into consideration:

- PE standards for specific activities;
- current clinical staff times from the prior review;
- inter-family relationships; and
- budget neutrality.

Although the total times were higher than the current times for all four codes, the expert panel agreed to be consistent with the policy for review of the office visit codes; specifically the recommended times cannot be greater than the current times. Below is a summary of the clinical staff current time,

recommended time and survey time for each survey code:

Surveyed CPT Code	Current Times	Recommended Times	Median of Total Time
99242	40	40	45
99243	55	52	57
99244	63	63	76
99245	73	73	92

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

Current PE inputs were included on the PE spreadsheet for the existing codes 99242-99245. Codes 99202-99205 were included as additional references.

3. Is this code(s) typically reported with an E/M service?
Is this code(s) typically reported with the E/M service in the nonfacility?
(Please see the *Billed Together* tab in the RUC Database)

N/A

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see the *Billed Together* tab in the RUC Database)

N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99242, 99243, 99244, 99245
SPECIALTY SOCIETY(IES): AADA, AAN, AANS, CNS, AAOS, AAP, AAHPM, ACC, ACG, AGA, ASGE, ACOG, ACR, ACS, ASCO, ASCRS, ASSH, ACNM, ATS, ACCP, NASS, SNMMI, STS, AATS, SVS
PRESENTER(S): Matthew Sideman, MD; Stephen Sentovich, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

N/A

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

N/A

8. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

9. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

99242, 99243, 99244. 99245 (5 minutes) weight, height, temperature, blood pressure, heart rate

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

Clinical staff will contact the patient and other sources to obtain pertinent prior imaging, lab and/or other test result(s) and prior medical records. This information will be added to the patient's office chart.

    b. Service period (includes pre, intra and post):

On the day of the consult, clinical staff will ensure that all pertinent information from the patient and other sources is available in the medical record; prepare the exam room; greet and gown the patient; obtain vital signs; review and document history, systems and medications as appropriate; identify prior imaging, labs, and/or tests that were not yet obtained that will be needed by the physicians; assist the physician as needed to position the patient for an exam; answer patient/family/caregiver questions about further imaging, labs and/or tests that are needed; and clean the room.

    c. Post-service period:

Clinical staff will coordinate, obtain and enter into the medical record results of post-encounter additional pertinent imaging, labs and/or other tests as requested by the consulting physician.

11. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

99245 - Clinical staff presents summary of relevant history to physician.

12. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99242, 99243, 99244, 99245
SPECIALTY SOCIETY(IES): AADA, AAN, AANS, CNS, AAOS, AAP, AAHPM, ACC, ACG, AGA, ASGE, ACOG, ACR, ACS, ASCO, ASCRS, ASSH, ACNM, ATS, ACCP, NASS, SNMMI, STS, AATS, SVS
PRESENTER(S): Matthew Sideman, MD; Stephen Sentovich, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

13. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):

N/A

14. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

Established pack: SA047 pack, E/M visit

19. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

pack, e/m visit	SA047	pack	5.0372
cover, thermometer probe		item	1
drape, non-sterile, sheet 40in x 60in		item	1
gloves, non-sterile		pair	2
gown, patient		item	1
paper, exam table		foot	7
patient education booklet		item	1
pillow case		item	1
specula tips, otoscope		item	1
swab-pad, alcohol		item	2
tongue depressor		item	1

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99242, 99243, 99244, 99245
SPECIALTY SOCIETY(IES): AADA, AAN, AANS, CNS, AAOS, AAP, AAHPM, ACC, ACG, AGA, ASGE, ACOG, ACR, ACS, ASCO, ASCRS, ASSH, ACNM, ATS, ACCP, NASS, SNMMI, STS, AATS, SVS
PRESENTER(S): Matthew Sideman, MD; Stephen Sentovich, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

22. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No

23. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

EF023 table, exam – Default Formula EF048 Portable stand-on scale – Two minutes allowed to obtain height and weight

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

For Information: **Clinical Staff Time 2019 Recommendation Process for Office Visit E/M Codes (per the RUC Rationale)** The specialty societies used the median total time for each CPT code, summing each respondents' total time recommendation, including times written in for "other clinical activity." The median total time served as the starting point for developing the recommendation to the PE Subcommittee. The specialty societies used the survey data, PE standards and current time inputs as the guiding principles for the recommended times and they also considered inter-family relationships (new versus established) and intra-family relationships (within new, within established). The recommended clinical activity time included in the spreadsheet is the survey times where those times do not exceed standard times or total current times. The PE Subcommittee confirmed that the median of total time from the survey includes time that the survey respondents wrote in for "other clinical activity." The Subcommittee also confirmed that the recommendations for individual clinical activities are the survey times where those times do not exceed standard times or current times and that is the reason that the median of total time from the survey is not identical to the recommended total clinical staff time.

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99242, 99243, 99244, 99245
SPECIALTY SOCIETY(IES): AADA, AAN, AANS, CNS, AAOS, AAP, AAHPM, ACC, ACG, AGA, ASGE, ACOG, ACR, ACS, ASCO, ASCRS, ASSH, ACNM, ATS, ACCP, NASS, SNMMI, STS, AATS, SVS
PRESENTER(S): Matthew Sideman, MD; Stephen Sentovich, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

The presenters responded to a question regarding the use of clinical activity, identify need for imaging, lab or other test result(s) and ensure information has been obtained - three days prior (to be used with E/M only) in the pre-service period and then repeating the same clinical activity, identify need for imaging, lab or other test result(s) and ensure information has been obtained - day of (to be used with E/M only) in the service period. This structure was approved by the Research Subcommittee and is repeated to capture the time that clinical staff spend performing this clinical activity regardless of whether they do it three days prior to the office visit or on the same day. For example, one clinical staff might spend 3 minutes preparing to see a patient on the day prior to a visit based on their own workflow pattern. Whereas, another clinical staff may perform all the pre-service work on the morning of the office visit. Therefore, both clinical staff would have responded differently on the survey for the times spent three days prior and on the date of service, but the total time would remain the same and is not duplicative. The specialty societies also explained that in many instances the clinical staff will identify the need for images and labs and find that the test is pending and will then need to go back on the day of the office visit to ensure that the information needed has been obtained. Survey respondents were instructed to include the time they would spend on the activity for a typical patient and were instructed that they should enter 0 if they do not perform any clinical activity in the three days prior to the office visit.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**REF (2019)**	**CURRENT (2003)**	**RECOMMENDED**	**REF (2019)**	**CURRENT (2003)**
2						**99202**	**99242**	**99242**	**99203**	**99243**
3						Office E/M, new patient, MDM Straightforward	Office Consult MDM Straightforward	Office Consult MDM Straightforward	Office E/M, new patient, MDM Low	Office Consult MDM Low
4	**Clinical Activity Code**	**Meeting Date:** October 2021 **Revision Date (if applicable):** **Tab:** 11 Consultation **Specialty:** See PE SoR for a list of the 25 societies that participated.	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**NF**	**NF**	**NF**	**NF**	**NF**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		***PE Survey Median Total Time***				**36 min**		**45 min**	**44 min**	
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
9		**TOTAL CLINICAL STAFF TIME**	L037D			**34**	**40**	**40**	**43**	**55**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**2**	**2**	**9**	**4**	**3**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**29**	**36**	**28**	**34**	**47**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**3**	**2**	**3**	**5**	**5**
13		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
14		**PRE-SERVICE PERIOD**								
15		**Start: Following visit when decision for surgery/procedure made**								
24	CA048		L037D			**2**	**2**	**9**	**4**	**3**
27		**End: When patient enters office/facility for surgery/procedure**								
28		**SERVICE PERIOD**								
29		**Start: When patient enters office/facility for surgery/procedure:**								
30		**Pre-Service (of service period)**								
31	CA009		L037D			**3**	**3**	**3**	**3**	**3**
32	CA010		L037D			**5**	**5**	**5**	**5**	**5**
35	CA013		L037D			**2**	**2**	**2**	**2**	**2**
38	CA016		L037D			**2**	**2**	**2**	**2**	**2**
40	CA049		L037D			**1**		**1**	**2**	
41	CA050		L037D			**10**	**10**	**10**	**12**	**15**
42			L037D							
47		**Intra-service (of service period)**								
50	CA020		L037D				**4**			**5**
58		**Post-Service (of service period)**								
61	CA024		L037D			**3**	**3**	**3**	**3**	**3**
64	CA051		L037D			**3**	**6**	**2**	**3**	**9**
65	CA052		L037D						**2**	
66	CA035		L037D				**1**			**3**
72		**End: Patient leaves office/facility**								
73		**POST-SERVICE PERIOD**								
74		**Start: Patient leaves office/facility**								
75	CA037		L037D							
76	CA038		L037D			**3**	**2**	**3**	**5**	**5**
90		**End: with last office visit before end of global period**								

	A	B	D	E	F	G	H	I	J	K
1	**RUC Practice Expense Spreadsheet**					**REF (2019)**	**CURRENT (2003)**	**RECOMMENDED**	**REF (2019)**	**CURRENT (2003)**
2						**99202**	**99242**	**99242**	**99203**	**99243**
3						Office E/M, new patient, MDM Straightforward	Office Consult MDM Straightforward	Office Consult MDM Straightforward	Office E/M, new patient, MDM Low	Office Consult MDM Low
4	**Clinical Activity Code**	**Meeting Date:** October 2021 **Revision Date (if applicable):** **Tab:** 11 Consultation **Specialty:** See PE SoR for a list of the 25 societies that participated.	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**NF**	**NF**	**NF**	**NF**	**NF**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		***PE Survey Median Total Time***				**36 min**		**45 min**	**44 min**	
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
9		**TOTAL CLINICAL STAFF TIME**	L037D			**34**	**40**	**40**	**43**	**55**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**2**	**2**	**9**	**4**	**3**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**29**	**36**	**28**	**34**	**47**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**3**	**2**	**3**	**5**	**5**
91	**Supply**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
92		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
93	SA047					**1**	**1**	**1**	**1**	**1**
94	SM022					**1**		**1**	**1**	
101	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
102		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
103	EQ189			Default		**29**	**36**		**34**	**47**
104	EF023			Default		**29**	**36**	**28**	**34**	**47**
105	EF048			Other Formula		**2**		**2**	**2**	

	A	B	L	M	N	O	P	Q	R
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**	**REF (2019)**	**CURRENT (2003)**	**RECOMMENDED**	**REF (2019)**	**CURRENT (2003)**	**RECOMMENDED**
2			**99243**	**99204**	**99244**	**99244**	**99205**	**99245**	**99245**
3			Office Consult MDM Low	Office E/M, new patient, MDM Moderate	Office Consult MDM Moderate	Office Consult MDM Moderate	Office E/M, new patient, MDM High	Office Consult MDM High	Office Consult MDM High
4	**Clinical Activity Code**	**Meeting Date:** October 2021 **Revision Date (if applicable):** **Tab:** 11 Consultation **Specialty:** See PE SoR for a list of the 25 societies that participated.							
5		**LOCATION**	**NF**	**NF**	**NF**	**NF**	**NF**	**NF**	**NF**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		***PE Survey Median Total Time***	**57 min**	**56 min**		**76 min**	**67 min**		**92 min**
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
9		**TOTAL CLINICAL STAFF TIME**	**52**	**54**	**63**	**63**	**67**	**73**	**73**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**12**	**6**	**4**	**15**	**10**	**4**	**18**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**35**	**41**	**53**	**41**	**46**	**61**	**44**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**5**	**7**	**6**	**7**	**11**	**8**	**11**
13		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
14		**PRE-SERVICE PERIOD**							
15		**Start: Following visit when decision for surgery/procedure made**							
24	CA048		**12**	**6**	**4**	**15**	**10**	**4**	**18**
27		**End: When patient enters office/facility for surgery/procedure**							
28		**SERVICE PERIOD**							
29		**Start: When patient enters office/facility for surgery/procedure:**							
30		**Pre-Service (of service period)**							
31	CA009		**3**	**3**	**3**	**3**	**3**	**3**	**3**
32	CA010		**5**	**5**	**5**	**5**	**5**	**6**	**5**
35	CA013		**2**	**2**	**2**	**2**	**2**	**2**	**2**
38	CA016		**2**	**2**	**2**	**2**	**2**	**2**	**2**
40	CA049		**2**	**3**		**3**	**5**		**5**
41	CA050		**12**	**14**	**15**	**14**	**14**	**16**	**14**
42									
47		**Intra-service (of service period)**							
50	CA020			**1**	**6**		**2**	**8**	**1**
58		**Post-Service (of service period)**							
61	CA024		**3**	**3**	**3**	**3**	**3**	**3**	**3**
64	CA051		**3**	**5**	**12**	**4**	**5**	**13**	**4**
65	CA052		**3**	**3**		**5**	**5**		**5**
66	CA035				**5**			**8**	
72		**End: Patient leaves office/facility**							
73		**POST-SERVICE PERIOD**							
74		**Start: Patient leaves office/facility**							
75	CA037								
76	CA038		**5**	**7**	**6**	**7**	**11**	**8**	**11**
90		**End: with last office visit before end of global period**							

	A	B	L	M	N	O	P	Q	R
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**	**REF (2019)**	**CURRENT (2003)**	**RECOMMENDED**	**REF (2019)**	**CURRENT (2003)**	**RECOMMENDED**
2			**99243**	**99204**	**99244**	**99244**	**99205**	**99245**	**99245**
3			Office Consult MDM Low	Office E/M, new patient, MDM Moderate	Office Consult MDM Moderate	Office Consult MDM Moderate	Office E/M, new patient, MDM High	Office Consult MDM High	Office Consult MDM High
4	**Clinical Activity Code**	**Meeting Date:** October 2021 **Revision Date (if applicable):** **Tab:** 11 Consultation **Specialty:** See PE SoR for a list of the 25 societies that participated.							
5		**LOCATION**	**NF**	**NF**	**NF**	**NF**	**NF**	**NF**	**NF**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		***PE Survey Median Total Time***	**57 min**	**56 min**		**76 min**	**67 min**		**92 min**
8		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
9		**TOTAL CLINICAL STAFF TIME**	**52**	**54**	**63**	**63**	**67**	**73**	**73**
10		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**12**	**6**	**4**	**15**	**10**	**4**	**18**
11		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**35**	**41**	**53**	**41**	**46**	**61**	**44**
12		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**5**	**7**	**6**	**7**	**11**	**8**	**11**
91	**Supply**	**MEDICAL SUPPLIES**							
92		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
93	SA047		**1**	**1**	**1**	**1**	**1**	**1**	**1**
94	SM022		**1**	**1**		**1**	**1**		**1**
101	**Equipment Code**	**EQUIPMENT**							
102		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
103	EQ189			**41**	**53**		**46**	**61**	
104	EF023		**35**	**41**	**53**	**41**	**46**	**61**	**43**
105	EF048		**2**	**2**		**2**			**2**

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2021

Nursing Facility Discharge Day Services – Tab 12

In April 2021, the RUC reviewed the initial and established patient nursing facility care services 99304-99310. At that time, when reviewing nursing facility discharge day services, CPT codes 99315 and 99316, the RUC determined these services should be reviewed with the hospital discharge day management codes, 99238 and 99239, in October 2021. Therefore, the RUC recommended to table review of CPT codes 99315 and 99316 until October 2021. However, at the October 2021 meeting, the hospital discharge day management codes 99238 and 99239 were postponed to be reviewed at the same time as the inpatient hospital and observation care codes, in January 2022. Upon further discussion of nursing facility discharge day services, the RUC determined that these services are distinct from the hospital discharge day management services and could be reviewed separate from the hospital discharge day management codes. As outlined in detail in the compelling evidence below, the nursing facility discharge day services are different due to management of the multiple electronic medical records and changes in nursing home care. These services have clinically distinct workflows and different patient populations. Therefore, the RUC determined that the nursing facility discharge services could be reviewed separately from the inpatient hospital discharge day services.

Compelling Evidence
The specialty societies indicated that there is compelling evidence based on a change in physician work due to changes in technology, patient population, and length of stay.

Change in physician work due to technology, specifically the use of multiple EMRs
Nursing facilities were slow to integrate electronic medical records (EMRs) into their workflow, because EMRs are not well suited for nursing facilities. In addition, the typical EMR system at a nursing facility is not interoperable with EMRs at other places of service. Physicians and other qualified health care professionals (QHPs) need to review and extract data from the nursing facility EMR to integrate into their standard work flow and documentation, usually outpatient based EMRs. Similarly, when orders or other interventions are made, documentation needs to occur in both systems, the nursing facility and outpatient EMR, respectively. There are no EMRs in this space that integrate meaningfully. The typical computer of a physician or QHP working in the nursing facility setting will utilize multiple EMRs depending on the number of nursing facilities or skilled nursing facilities (SNFs) the individual works with. The necessary duplication of documentation across systems creates more provider work, especially on patient discharge, where problems such as medications and follow-up need to be reconciled, documented, and acted upon in two systems.

Change in physician work due to change in patient population and length of stay
Data supports that since the discharge codes were last reviewed in 2010, the length of stay in the nursing home has decreased. According to the March 2021 Medicare Payment Advisory Commission (MedPAC) Report to Congress, the number of covered days per admission in the SNF has decreased from 27.1 in 2010 to 24.8 in 2019, a decrease of 8.5%. This is coupled with shorter hospital stays and faster discharge from the nursing facility. Further, the March 2020 MedPAC Report to Congress includes data documenting mean risk-adjusted rates of community discharge have

increased from 35.7% in 2012 to 41.4% in 2018, during which time readmits during the SNF stay decreased from 11.4 to 10.6%. This supporting evidence signals that more physician work is focused on discharging patients earlier and more often safely to home.
The acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. Data provided in the summary of recommendation (SOR) shows the increase in patient acuity upon hospital discharge (based on the Elixhauser Comorbidity Index, which is a method of categorizing comorbidities of patients based on the International Classification of Diseases) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing facility visits. The specialty societies also referenced multiple studies demonstrating changes in physician work due to increased complexity of the patient population.

The RUC concurred that there is compelling evidence that the physician work for these services has changed based on changes in technology and change in patient population and length of stay.

99315 ***Nursing facility discharge day management; 30 minutes or less***
The RUC reviewed the survey results from 185 physicians and other qualified health care professionals and determined that the 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes of pre-service evaluation time, 25 minutes of intra-service time and 5 minutes of post-service time.

The RUC compared CPT code 99315 to nursing facility visit code 99304 *Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.* (April 2021 RUC recommended work RVU = 1.50 and 25 minutes intra-service time) and determined that these services were surveyed by the same set of respondents in April 2021 and require the same intra-service time and similar total time, 40 and 36 minutes, respectively. The RUC noted that maintaining code 99315 at the current value of 1.28 would not be appropriate and would cause a rank order anomaly with 99308 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded*. (April 2021 RUC recommended work RVU = 1.30 and 18 minutes intra-service time).

For additional support, the RUC referenced MPC code 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 25 minutes on the date of encounter time), MPC code 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 29 minutes intra-service time), CPT code 74181 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)* (work RVU = 1.46 and 20 minutes intra-service time), CPT code 78830 *Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging* (work RVU = 1.49 and 25 minutes intra-service time) and 10005 *Fine needle aspiration biopsy, including ultrasound guidance; first lesion* (work RVU = 1.46 and 20 minutes intra-service time), all which require similar physician work and time. The RUC concluded that CPT code 99315 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 1.50 for CPT code 99315.**

99316 ***Nursing facility discharge day management; more than 30 minutes***
The RUC reviewed the survey results from 191 physicians and other QHPs and determined that the 25th percentile work RVU of 2.50 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes of pre-service evaluation time, 40 minutes of intra-service time and 8 minutes of post-service time.

The RUC compared CPT code 99316 to nursing facility visit code 99305 *Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.* (April 2021 RUC recommended work RVU = 2.50 and 35 minutes intra-service time) and determined that these services were surveyed by the same set of respondents in April 2021 and require the similar intra-service time of 40 and 35 minutes and similar total time, 63 and 55 minutes, respectively. The RUC also compared 99316 to nursing facility visit code 99309 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.* (April 2021 RUC recommended work RVU = 1.92, 30 minutes intra-service time and 47 minutes total time) and noted that if 99316 was maintained at the current value of 1.90, it would cause a rank order anomaly with the previously recommended value for moderate MDM subsequent nursing facility care code 99309.

For additional support, the RUC referenced MPC code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.40 and 39 minutes intra-service time), CPT code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU = 2.50 and 36.5 minutes intra-service time) and MPC code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU = 2.60 and 40 minutes intra-service time), all which require similar physician work and time. The RUC concluded that CPT code 99316 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 2.50 for CPT code 99316.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty societies.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

Evaluation and Management

Nursing Facility Services

The following codes are used to report evaluation and management services to patients in nursing facilities and skilled nursing facilities ~~(formerly called skilled nursing facilities [SNFs], intermediate care facilities [ICFs], or long-term care facilities [LTCFs])~~. These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center and intermediate care facility for individuals with intellectual disabilities. ~~(a facility or a distinct part of a facility for psychiatric care, which provides a 24-hour therapeutically planned and professionally staffed group living and learning environment). If procedures such as medical psychotherapy are provided in addition to evaluation and management services, these should be reported in addition to the evaluation and management services provided.~~

~~Nursing facilities that provide convalescent, rehabilitative, or long term care are required to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity using a Resident Assessment Instrument (RAI). All RAIs include the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs), and utilization guidelines. The MDS is the primary screening and assessment tool; the RAPs trigger the identification of potential problems and provide guidelines for follow-up assessments.~~

Regulations pertaining to the care of nursing facility residents govern the nature and minimum frequency of assessments and visits. These regulations also govern who may perform the initial comprehensive visits.

These services are performed by the principal physician(s) and other qualified health care professional(s), overseeing the care of the patient in the facility. The principal physician is sometimes referred to as the admitting physician and is the physician who oversees the patient's care as compared to other physicians or other qualified health care professionals who may be furnishing specialty care. These services are also performed by physicians or other qualified health care professionals in the role of a specialist performing a consultation or concurrent care. Modifiers may be required to identify the role of the individual performing the service.

~~Physicians have a central role in assuring that all residents receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the residents' physical and psychosocial functioning. This role includes providing input in the development of the MDS and a multi-disciplinary plan of care, as required by regulations pertaining to the care of nursing facility residents.~~

Two major subcategories of nursing facility services are recognized: Initial Nursing Facility Care and Subsequent Nursing Facility Care. Both subcategories apply to new or established patients.

The types of care (eg, skilled nursing facility and nursing facility care) are reported with the same codes. Place of service codes should be reported to specify the type of facility (and care) where the service(s) are performed.

*For definitions of commonly used terms, see **Evaluation and Management Services Guidelines.***

When selecting a level of medical decision making (MDM) for nursing facility services, the Nature and Complexity of Problems Addressed at the Encounter is considered. For this determination, a high level MDM type specific to Initial Nursing Facility Care by the principal physician or other qualified health care professional is recognized. This type is:

Multiple morbidities requiring intensive management: A set of conditions, syndromes or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.

The definitions and requirements related to the Amount and Complexity of Data to be Reviewed and Analyzed and the Risk of Complications and/or Morbidity or Mortality of Patient Management are unchanged.

~~(For care plan oversight services provided to nursing facility residents, see 99379-99380)~~

Initial Nursing Facility Care
New or Established Patient

When the patient is admitted to the nursing facility in the course of an encounter in another site of service (eg, hospital emergency department, office), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or qualified health care professional was performed on the same date. ~~all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as the admission or readmission. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the nursing facility setting.~~

In the case when services in a separate site are reported and the initial nursing facility care service is a consultation service by the same physician or other qualified health care professional and reported on the same date, do not report 99304, 99305, 99306, 99252, 99253, 99254, 99255. The consultant reports the subsequent nursing facility care codes 99307, 99308, 99309, 99310 for the second service on the same date.

Hospital inpatient ~~discharge~~ or observation discharge services performed on the same date of nursing facility admission or readmission may be reported separately. For a patient discharged from inpatient or observation status on the same date of nursing facility admission or readmission, the hospital or observation discharge services ~~should~~ may be reported with codes 99238, 99239 as appropriate. ~~For a patient discharged from observation status on the same date of nursing facility admission or readmission, the observation care discharge services should be reported with code 99217.~~ For a patient admitted and discharged from observation or inpatient status on the same date, see codes 99234- 99236. Time related to ~~these~~ hospital inpatient or observation care services may not be used for code selection of any nursing facility service.

~~(For nursing facility care discharge, see 99315, 99316)~~

Initial nursing facility care codes 99304, 99305, 99306 may be used once per admission, per physician or other qualified health care professional, regardless of length of stay. They may be used for the initial comprehensive visit performed by the principal physician or other qualified health care professional. Skilled nursing facility initial comprehensive visits must be performed by a physician. Qualified health care professionals may report initial comprehensive nursing facility visits for nursing facility level of care patients, if allowed by state law or regulation. The principal physician or qualified health care professional may work with others (who may not always be in the same group) but are overseeing the overall medical care of the patient, in order to provide

timely care to the patient. Medically necessary assessments conducted by these professionals prior to the initial comprehensive visit are reported using subsequent care codes (99307, 99308, 99309, 99310).

Initial services by other physicians and other qualified health care professionals who are performing consultations may be reported using initial nursing facility care codes (99304, 99305, 99306) or inpatient consultations (99252, 99253, 99254, 99255). This is not dependent upon the principal care professionals completion of the initial comprehensive services first.

An initial service may be reported when the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses or physician assistants are working with physicians they are considered as working in the exact same specialty and subspecialty as the physician. An initial service may also be reported if the patient is a new patient as defined in the Evaluation and Management Guidelines.

For reporting initial nursing facility care, transitions between skilled nursing facility level of care ad nursing facility level of care do not constitute a new stay.

~~***Coding Tip***~~

~~**The Significance of Time as a Factor in Selection of an Evaluation and Management Code from This Section**~~

~~The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services included in codes in this section. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.~~

~~**Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99251, 99252, 99253, 99254, 99255], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]):**~~

~~For coding purposes, time for these services is defined as unit/ floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.~~

~~CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Time~~

▲99304	I1	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. ~~these 3 key components:~~ ~~• **A detailed or comprehensive history;**~~ ~~• **A detailed or comprehensive examination; and**~~ ~~• **Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.	XXX	1.50 (April 2021 RUC Recommendation)
▲99305	I2	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ ~~• **A comprehensive history;**~~ ~~• **A comprehensive examination; and**~~ ~~• **Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	XXX	2.50 (April 2021 RUC Recommendation)
▲99306	I3	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components:~~ ~~• **A comprehensive history;**~~ ~~• **A comprehensive examination; and**~~	XXX	3.50 (April 2021 RUC Recommendation)

		• ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. (For services 60 minutes or longer, use prolonged services code 993X0)		
Subsequent Nursing Facility Care ~~All levels of subsequent nursing facility care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment by the physician or other qualified health care professional.~~				
▲99307	I4	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A problem focused interval history;**~~ • ~~**A problem focused examination;**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	XXX	0.70 (April 2021 RUC Recommendation)
▲99308	I5	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**An expanded problem focused interval history;**~~ • ~~**An expanded problem focused examination;**~~	XXX	1.30 (April 2021 RUC Recommendation)

		~~• **Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.		
▲99309	I6	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~at least 2 of these 3 key components:~~ ~~• **A detailed interval history;**~~ ~~• **A detailed examination;**~~ ~~• **Medical decision making of moderate complexity**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	XXX	1.92 (April 2021 RUC Recommendation)
▲99310	I7	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~at least 2 of these 3 key components:~~ ~~• **A comprehensive interval history;**~~ ~~• **A comprehensive examination;**~~ ~~• **Medical decision making of high complexity**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.~~	XXX	2.80 (April 2021 RUC Recommendation)

		When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. (For services 60 minutes or longer, use prolonged services code 993X0)		
Nursing Facility Discharge Services The nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician or other qualified health care professional for the final nursing facility discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent on that date is not continuous. Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. These services require a face-to-face encounter ~~but~~ that may be performed on a calendar date prior to the actual discharge date. The time of the face-to-face encounter performed on a date prior to the discharge date is counted toward 99315, 99316 and not reported separately.				
(f)99315	I8	Nursing facility discharge day management; 30 minutes or less	XXX	1.50
(f)99316	I9	more than 30 minutes	XXX	2.50
Other Nursing Facility Services				
~~D99318~~	-	~~Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making that is of low to moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.~~ ~~(Do not report 99318 on the same date of service as nursing facility services codes 99304-99316)~~ (99318 has been deleted. To report, see 99307, 99308, 99309, 99310)	~~XXX~~	~~N/A~~ ~~(2021 work RVU = 1.71)~~

CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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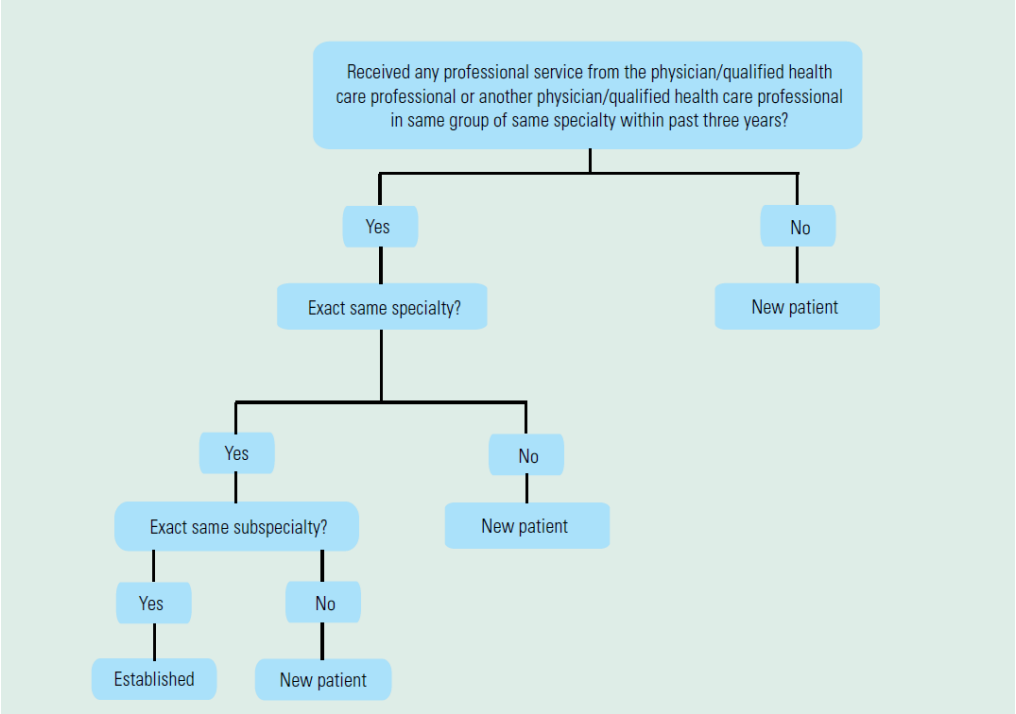
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99315 Tracking Number I8 Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.50**
Global Period: XXX Current Work RVU: **1.28** RUC Recommended RVU: **1.50**

CPT Descriptor: Nursing facility discharge day management, 30 minutes or less

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Final nursing facility day visit for a 72-year-old male with congestive heart failure and multiple comorbidities, who is being discharged home on diet and oral medications.

Percentage of Survey Respondents who found Vignette to be Typical: 80%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review data from faxes, telephone calls, and other telecommunications regarding the patient's status since the last visit related to any new medical issues. Communicate with facility nursing staff and therapy staff, other health care professionals, and family members regarding patient status and pending discharge plans.

Description of Intra-Service Work: Review medical records and other available data. Obtain an interval history and perform a physical examination. Formulate and/or revise diagnosis and treatment plan(s), including making the decision for discharge. Review information regarding availability, safety, and adequacy of post-discharge support systems. Discuss aftercare treatment with patient, family and/or caregivers and other health care professionals. Provide care coordination for transition that includes instructions to caregivers for aftercare. Arrange for post-discharge follow-up professional services and testing as necessary. Reconcile patient's medications with attention to pre-admission therapy, inpatient therapy, and outpatient formulary. Write prescriptions as necessary. Complete discharge and aftercare forms. Inform referring physician of discharge plans. Complete medical record documentation.

Description of Post-Service Work: Complete discharge records. Respond and attend to any treatment failures, negative outcomes, medication refill requests, or adverse medication reactions that may occur after discharge until the primary care physician assumes care. Provide necessary care coordination, telephonic or electronic communication assitance, and other necessary management related to this facility stay. Receive and respond to any interval testing results or correspondence, including obtaining results pending at discharge, until the primary care physician assumes care. Revise treatment plan(s) and communicate with patient and/or caregiver, as necessary, until the primary care physician assumes care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, Korinne Van Keuren, DNP, APRN					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA					
CPT Code:	99315					
Sample Size:	5903	**Resp N:**	185			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**10.00**	28.00	450.00	
Survey RVW:	0.50	1.50	**2.10**	2.78	8.00	
Pre-Service Evaluation Time:			**10.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	0.00	20.00	**25.00**	30.00	125.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99315	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99495	XXX	2.78	**RUC Time**

CPT Descriptor Transitional Care Management Services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of at least moderate complexity during the service period, face-to-face visit, within 14 calendar days of discharge

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a mdecially appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.60	**RUC Time**	11,452,897

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95861	XXX	1.54	**RUC Time**	44,204

CPT Descriptor 2 Needle electromyography; 2 extremities with or without related paraspinal areas

Other Reference CPT Code	Global	Work RVU	Time Source
74181	XXX	1.46	**RUC Time**

CPT Descriptor Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 78 **% of respondents:** 42.1 **%**

Number of respondents who choose 2nd Key Reference Code: 33 **% of respondents:** 17.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 99315	Top Key Reference CPT Code: 99495	2nd Key Reference CPT Code: **99214**
Median Pre-Service Time	10.00	0.00	7.00
Median Intra-Service Time	25.00	47.00	30.00
Median Immediate Post-service Time	5.00	0.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**40.00**	**47.00**	**47.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	12%	35%	44%	10%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	17%	45%	39%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	12%	58%	30%
Physical effort required	8%	60%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	40%	52%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	3%	12%	37%	33%	15%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	24%	30%	45%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	9%	48%	42%
Physical effort required	9%	45%	45%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	12%	30%	57%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed but were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such

assessments are not required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

Our expert panel identified two compelling evidence arguments relevant to the discharge codes 99315 and 99316. These include change in physician work due to technology and change in physician work due to change in patient population and length of stay. These arguments are described in detail below.

Change in physician work due to technology, specifically the use of multiple EMRs. Nursing facilities were slow to integrate EMR in their workflow, utilizing EMR that were nursing facility and not physician /provider friendly. Physicians and other QHP need to review and extract data from the nursing facility EMR to integrate into their standard work usually outpatient based EMR such as Epic or Cerner. Similarly, when orders or other interventions are made, documentation needs to occur in both systems. There are no EMRs in this space that integrate meaningfully. The typical computer of a physician or QHP working in this setting will have multiple EMR on it depending on the number of nursing facilities or skilled nursing facilities the individual works with. The necessary duplication of documentation across systems makes for more provider work especially on discharge where problems such as medications and follow-up need to be reconciled, documented, and acted upon in two systems.

Change in physician work due to change in patient population and length of stay. Data supports that since the discharge codes were last reviewed in 2010, the length of stay in the nursing home has decreased. According to the March 2021 MedPAC Report to Congress, the number of covered days per admission in the SNF has decreased from 27.1 in 2010 to 24.8 in 2019; a decrease of 8.5%. This is coupled with shorter hospital stays and faster discharge to the nursing facility. Further, the March 2020 MedPAC Report to Congress includes data documenting mean risk adjusted rates of community discharge have increased from 35.7% in 2012 to 41.4% in 2018 during which time readmits during the SNF stay decreased from 11.4 to 10.6%. These points also support more physician work discharging earlier and more often safely to home.

The acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org,

a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting.

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

Survey Data Review

The expert panel reviewed code 99315 which is for discharge day management, 30 minutes or less. This code was not changed but is part of the family. There were 185 respondents of whom 81% found the vignette to be typical. The survey times and median work RVU were 10/25/5/40/2.10 and the 25th percentile work RVU was 1.50. The two key reference services were 99495, Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge, which has times and work RVU of 0/54/0/54/2.78, and 99214, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter, with times and work RVUs of 7/30/10/47/1.92.

The expert panel noted that the current times and work RVU for 99315 are 10/20/10/40/1.28.

The expert panel noted that while the survey total time was the same as the current total time, the intra time was five minutes higher. The expert panel also agreed that 99315 should be valued lower than both key reference services. The panel compared the survey intra time and 25th percentile work RVU to those for both key reference services. For 99495, the intra time of 54 minutes for 99495 is 216% higher than the intra survey time and the work RVU of 2.78 is 185% higher than the survey 25th percentile. For 99214 the intra time of 30 minutes is 20% higher then the survey intra time, the total time of 47 minutes is 17% more than the survey total time, and the work RVU of 1.92 is 28% more than the survey 25th percentile RVU. Therefore, the survey 25th percentile RVU places 99315 in proper rank order with both key reference services.

The expert panel also looked at two MPC codes, 99203, New patient visit requiring low level medical decision making with times and work RVU of 5/25/5/35/1.6, and 95861, Muscle test two limbs with times and work RVU of 10/29/10/49/1.54.

The expert panel agreed that the survey times and 25th percentile work RVU of 10/25/5/40/1.5 places 99315 in correct rank order with both these MPC codes.

Therefore, the expert panel recommends for 99315, times and work RVU of 10/25/5/40/1.5.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4
99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99315

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner	How often? Sometimes
Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 309110
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors

Specialty Nurse Practitioners	Frequency 110043	Percentage 35.59 %
Specialty Internal Medicine	Frequency 94279	Percentage 30.50 %
Specialty Family Medicine	Frequency 59967	Percentage 19.39 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 251,226 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC Database

Specialty Nurse Practitioner	Frequency 89436	Percentage 35.59 %
Specialty Internal Medicine	Frequency 76624	Percentage 30.50 %
Specialty Family Medicine	Frequency 48738	Percentage 19.40 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99315

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99316 Tracking Number I9 Original Specialty Recommended RVU: **2.50**
Presented Recommended RVU: **2.50**
Global Period: XXX Current Work RVU: **1.90** RUC Recommended RVU: **2.50**

CPT Descriptor: Nursing facility discharge day management; more than 30 minutes

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Final nursing facility day visit for an 84-year-old male who suffered a cerebrovascular accident with hemiparesis and who has congestive heart failure, peripheral vascular disease, and diabetes. The patient needs help transferring and is unable to administer his own insulin but has adequate supports at home to be discharged to the community.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review data from faxes, telephone calls, and other telecommunication regarding patient's staus since the last visit related to any new medical issues. Communicate with facility nursing and therapy staff, other health care professionals, and family members refarding patient status and pending discharge plans.

Description of Intra-Service Work: Review medical records and other available data. Obtain an interval hisotry and perform a physical examination. Consider relevant data, options, and risks and formulate and/or revise diagnosis and treatment plan(s0, including making the decision for discharge. Review information regarding the availability, adequacy, and safety of post-discharge support systems. Discuss aftercare treatment with patient, family, and/or caregivers and other healthcare profressionals. Provide care coordiantion for the transition, including instructions to caregivers for aftercare. Arrange for post-discharge follow up professional services and testing. Reconcile patient's medications with attention to pre-admission therapy, inpatient therapy, and outpatient formulary. Write prescriptions as necessary. Complete discharge and aftercare forms. Inform the referring physician or discharge plans. Complete medical record documentation.

Description of Post-Service Work: Complete discharge records. Respond to any treatment failures, negative outcomes, medication refill requests, or adverse medication reactions that may occur after discharge until the primary care physician assumes care. Provide necessary care coordiation, telephonic or electronic communication assistance, and other necessary management related to this facility stay. Receive and respond to any interval testing results or correspondence, including obtaining any results pending at discharge, until the primary care physician assumes care. Revise treatment plan(s) and communicate with patient and/or caregiver as ncessary, until the primary care physician assumes care.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, Korinne Van Keuren, DNP, APRN					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA					
CPT Code:	99316					
Sample Size:	5903	**Resp N:**	191			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**10.00**	40.00	800.00	
Survey RVW:	0.75	2.50	**3.01**	3.80	9.00	
Pre-Service Evaluation Time:			**15.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	0.00	30.00	**40.00**	50.00	120.00	
Immediate Post Service-Time:	**8.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99316	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**40.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**8.00**	**0.00**	**8.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99496	XXX	3.79	**RUC Time**

CPT Descriptor Transitional Care Management Services with the following required elements: communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge, medical decision making of high complexity during the service period, face-to-face visit, within 7 calendar days of discharge

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.60	**RUC Time**	10,714,246

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
75635	XXX	2.40	**RUC Time**	114,472

CPT Descriptor 2 Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Other Reference CPT Code	Global	Work RVU	Time Source
95810	XXX	2.50	**RUC Time**

CPT Descriptor Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 88 **% of respondents:** 46.0 **%**

Number of respondents who choose 2nd Key Reference Code: 38 **% of respondents:** 19.8 **%**

TIME ESTIMATES (Median)

	CPT Code: 99316	Top Key Reference CPT Code: 99496	2nd Key Reference CPT Code: **99215**
Median Pre-Service Time	15.00	0.00	10.00
Median Intra-Service Time	40.00	60.00	45.00
Median Immediate Post-service Time	8.00	0.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**63.00**	**60.00**	**70.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	10%	22%	41%	27%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	34%	54%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	48%	44%
Physical effort required	6%	56%	39%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	25%	64%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	3%	3%	16%	53%	26%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	16%	18%	65%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	45%	50%
Physical effort required	6%	39%	45%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	11%	16%	73%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed but were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments are not required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

Our expert panel identified two compelling evidence arguments relevant to the discharge codes 99315 and 99316. These include change in physician work due to technology and change in physician work due to change in patient population and length of stay. These arguments are described in detail below.

Change in physician work due to technology, specifically the use of multiple EMRs. Nursing facilities were slow to integrate EMR in their workflow, utilizing EMR that were nursing facility and not physician /provider friendly. Physicians and other QHP need to review and extract data from the nursing facility EMR to integrate into their standard work usually outpatient based EMR such as Epic or Cerner. Similarly, when orders or other interventions are made, documentation needs to occur in both systems. There are no EMRs in this space that integrate meaningfully. The typical computer of a physician or QHP working in this setting will have multiple EMR on it depending on the number of nursing facilities or skilled nursing facilities the individual works with. The necessary duplication of documentation across systems makes for more provider work especially on discharge where problems such as medications and follow-up need to be reconciled, documented, and acted upon in two systems.

Change in physician work due to change in patient population and length of stay. Data supports that since the discharge codes were last reviewed in 2010, the length of stay in the nursing home has decreased. According to the March 2021 MedPAC Report to Congress, the number of covered days per admission in the SNF has decreased from 27.1 in 2010 to 24.8 in 2019; a decrease of 8.5%. This is coupled with shorter hospital stays and faster discharge to the nursing facility. Further, the March 2020 MedPAC Report to Congress includes data documenting mean risk adjusted rates of community discharge have increased from 35.7% in 2012 to 41.4% in 2018 during which time readmits during the SNF stay decreased from 11.4 to 10.6%. These points also support more physician work discharging earlier and more often safely to home.

The acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting.

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

Survey Data Review

The expert panel reviewed code 99316, discharge day management, more than 30 minutes. This code was not changed but is part of the family. There were 191 respondents of whom 94% fund the vignette to be typical. The survey times and median work RVU were 15/40/8/63/3.01 and the 25th percentile work RVU was 2.5. The key reference services were 99496, Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge, with times and work RVU of 0/75/0/75/3.79, and 99215, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/45/15/70/2.80.

The expert panel noted that the current times and work RVU for 99316 are 14/25/15/54/1.90.

The expert panel noted that the survey intra time is 15 minutes (60% greater) more than the current intra time and the survey total time of 63 minutes is nine minutes (17% greater) more than the current total time. The expert then compared the survey data to the reference services. The total time for 99215 is 11% higher than the survey total time, the intra time of 45 minutes is 12% higher than the survey intra time, and the work RVU of 2.80 is 12% higher than the survey 25th percentile work RVU. The intra time for 99496 is 87% more than the survey intra time, and 19% more than the survey total time and the work RVU of 3.79 is 51% more than the survey 25th percentile work RVU.

The expert panel believes that the 25th percentile work RVU of 2.5 please 99316 in correct rank order with the key reference services. In addition, the expert panel reviewed two MPC codes, 99204, New patient visit requiring moderate level medical decision making with times and work RVU of 10/40/10/60/2.6, and 75635, Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing, with times and work RVU of 10/39/8/57/2.4. The expert panel believe that the survey 25th percentile work RVU places 99316 in correct rank order to these two MPC codes.

Therefore, the expert panel recommends times and work RVU for 99316 of 15/40/8/63/2.5.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4
99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99316

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioners	How often? Sometimes
Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 519002
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors

Specialty Nurse Practitioner	Frequency 257425	Percentage 49.60 %
Specialty Internal Medicine	Frequency 128712	Percentage 24.79 %
Specialty Family Medicine	Frequency 52938	Percentage 10.19 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 447,543 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC database

Specialty Nurse Practitioner	Frequency 221981	Percentage 49.59 %
Specialty Internal Medicine	Frequency 110991	Percentage 24.80 %
Specialty Family Practice	Frequency 45649	Percentage 10.19 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99316

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

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Original Study

Thirty-Year Trends in Nursing Home Composition and Quality Since the Passage of the Omnibus Reconciliation Act

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Keywords:
Quality
Nursing Home Reform Act
OBRA 1987
nursing home characteristics

A B S T R A C T

Objective: In 1987, the Omnibus Reconciliation Act (OBRA) called for a dramatic overhaul of the nursing home (NH) quality assurance system. This study examines trends in facility, resident, and quality characteristics since passage of that legislation.
Methods: We conducted univariate analyses of national data on US NHs from 3 sources: (1) the 1985 National Nursing Home Survey (NNHS), (2) the 1992-2015 Online Survey Certification and Reporting (OSCAR) Data, and (3) LTCfocUS data for 2000-2015. We examined changes in NH characteristics, resident composition, and quality.
Setting and participants: US NH facilities and residents between 1985 and 2015.
Results: The proportion of NHs that are Medicare and Medicaid certified, members of chains, and operating not-for-profit has increased over the past 30 years. There have also been reductions in occupancy and increases in the share of residents who are racial or ethnic minorities, admitted for post-acute care, in need of physical assistance with daily activities, primarily supported by Medicare, and diagnosed with a psychiatric condition such as schizophrenia. With regard to NH quality, direct care staffing levels have increased. The proportion of residents physically restrained has decreased dramatically, coupled with changes in inappropriate antipsychotic (chemical restraint) use.
Conclusions and implications: Together with changes in the long-term care market, the NHs of today look very different from NHs 30 years ago. The 30th anniversary of OBRA provides a unique opportunity to reflect, consider what we have learned, and think about the future of this and other sectors of long-term care.

For more than 30 years, the quality of nursing home (NH) care has been a continuous concern.[1] In 1984, following published reports and concerns about resident abuse, neglect, and a lack of regulation and oversight, Congress asked the Institute of Medicine (IOM) to investigate the quality of NHs and make recommendations for improvement. The resulting report proposed radical NH reforms,[2] many of which were codified by Congress as part of the Nursing Home Reform Act of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).

OBRA 1987 created regulations for NHs in an effort to improve the quality of care delivered to residents. OBRA included a minimum set of care standards and rights for people residing in Medicare- and Medicaid-certified NHs. OBRA 1987 had a focus on residents' quality of life and care, expectations for improved or maintained resident health, as well as residents' rights to banking, organized family councils, and freedom from unnecessary physical and chemical restraints. The Act also standardized certification standards and enforcement strategies. As such, OBRA 1987 was an overhaul of the NH industry and marked a new beginning for NH care and regulation.

In the 30+ years since OBRA 1987, there have been a number of other changes that have directly affected the NH industry. In response

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VM is chair, Independent Quality Committee, of HCR Manor Care; is chair, Scientific Advisory Board, and consultant for NaviHealth, Inc; and former director, PointRight, Inc (holds less than 1% equity). The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs, the National Institutes of Health, or the United States government.

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to consumer preferences to remain in the community, "age-in-place," and efforts to rebalance states' long-term care budgets,[3–5] there has been a considerable increase in home- and community-based services (HCBS). HCBS were seen as mechanisms to divert or delay expensive, and often undesired, NH placement. Over the last several decades, states have begun funding more HCBS, primarily through Medicaid waiver programs; and, for the first time in 2013, states spent more on HCBS than care provided in NHs.[6] Accompanying these care delivery, market, and financing changes has been growth of an aging and diversifying population, as well as a number of laws and regulations directly impacting the NH industry (eg, the Balanced Budget Act of 1997 and the introduction of case-mix reimbursement).

The purpose of this study was to summarize changes in the NH industry in the 30 years since the seminal regulatory change affecting NHs. Specifically, we use historical data from 3 national sources and describe changes in NH facility characteristics, resident characteristics, and quality of care from 1985 through 2015. The 30th Anniversary of OBRA provides a unique opportunity to examine the changes within this vitally important industry. This article can aid in understanding long-term trends, as well as provide insight into what changes we might expect in the future.

Methods

Data

We analyzed data from 3 sources to examine resident and facility characteristics, longitudinally: (a) National Nursing Home Survey, (b) Online Survey Certification and Reporting Data/Certification and Survey Provider Enhanced Reporting, and (c) LTCFocUS data.

National Nursing Home Survey (NNHS)

The National Center for Health Statistics conducted the NNHS. The NNHS consists of a nationally representative sample of more than 1,000 NHs and their residents. NHs included in the surveys had at least 3 or more beds and were Medicare or Medicaid certified or had a state license to operate as an NH. The facilities and residents were selected by a stratified 2-stage probability design. In the first stage, NHs were selected, and in the second stage, residents were sampled from the selected NHs. NNHS data were used to describe facility and aggregated resident characteristics. Data for these analyses came from the University of Michigan ICPSR public use NNHS data files for 1985.[7]

Online Survey Certification and Reporting Data (OSCAR)/ Certification and Survey Provider Enhanced Reporting (CASPER)

CMS' OSCAR/CASPER database is a national database of all NH data elements collected by state survey agencies during the required annual onsite Medicare and Medicaid Certification inspection. The inspections occur at least once during a 15-month period. OSCAR/CASPER data are used to determine facility characteristics, deficiencies in care noted during the survey, and aggregated resident data. Data included all certified NHs between the years 1992 and 2015. Variables in OSCAR/CASPER have been validated for research purposes.[8]

Long-Term Care FocUS (LTCFocUS)

We used LTCFocUS.org, a product of the Shaping Long-Term Care in America Project at the Brown University Center for Gerontology and Healthcare Research and supported, in part, by the National Institute on Aging (www.ltcfocus.org). This data set included information for years 2000-2015 and combined variables from the OSCAR data; the Minimum Data Set (MDS), resident-level data related to resident clinical and functional status; the Area Resource File (ARF), a national county-level health resources database maintained by the Health Resources and Services Administration that contains data about the health professionals and facilities in each county; and the Residential History File, a data resource built using Medicare Enrollment data, Medicare claims data, and assessment data to track individuals as they move through the long-term care system.[9] For these analyses, we used the LTCFocUS data to describe the aggregated characteristics of residents served in NHs between 2000 and 2015.

Variables

We included the following facility characteristics to describe changes in the NH market over time: dual certification for Medicare and Medicaid, multifacility chain membership, for-profit status (vs nonprofit or government), presence of an Alzheimer's special care unit, facility size (ie, total number of beds), and occupancy rate.

To describe the resident composition, we included demographic characteristics, length of stay, admission source, physical function, mental health diagnoses, and medication use measures. Demographic variables from LTCfocUS included the percentage of female residents in each facility; the percentage of blacks, whites, and Hispanics in each facility; and the average age for residents residing in each facility. Also from the LTCfocUS, we included the percentage of long-stay residents, defined as the percentage of residents in the NH at least 90 of the last 100 days. We also include the percentage of residents admitted to the NH directly from the hospital vs the community or other LTC setting. From the OSCAR/CASPER, we included information about residents' primary payer as the percentage of residents whose primary support was Medicaid or Medicare. Measures of resident physical and cognitive function included the facility's average Activities of Daily Living (ADL) scale score, bed/chair bound measures, individual early-, middle-, and late-loss ADL, and the percentage of residents with dementia. The ADL scale score comes from LTCFocUS, ranges from 0 to 28, and is created by summing 7 ADL items on a scale from 0 to 4 (with 0 = complete independence and 4 = total dependence for each item). The facility average represents the average across all residents in the facility. Chairbound and bedbound measures come from the NNHS and OSCAR/CASPER data and refer to the percentage of residents unable to leave their chair or bed, respectively, at the time of the survey. The individual ADL of interest from the NNHS and OSCAR/CASPER data include dressing, bathing, transferring, toileting, and eating, and represent the percentage of residents who were not completely independent in each of these activities at the time of the survey. From the NNHS and OSCAR/CASPER data, we also included a measure for the percentage of residents with dementia within the facility. Measures of resident mental health and medication use included the percentage of residents with a psychiatric diagnosis (excluding dementia and depression), a schizophrenia diagnosis, receiving antianxiety medications, receiving antidepressants, and receiving antipsychotics.

Information on facility quality consisted of structure, process, and outcome measures.[10] As a measure of structure, we included the number of certified nursing aides, licensed professional nurses, and registered nurse hours per resident per day from the OSCAR/CASPER data. We obtained information about facilities' quality process measures including the percentage of residents in a facility who were physically restrained, received tube feeding, had a catheter, received antipsychotic medications without a diagnosis of schizophrenia or bipolar disorder at the time of the survey, and the percentage of facilities experiencing medication errors. Medication error refers to the percentage of facilities cited for drug error rates higher than 5% reported during the annual survey. Quality outcome measures included the percentage of residents within a facility with pressure ulcers, and the percentage of residents within a facility experiencing incontinence. Values for pressure ulcers indicate the percentage of residents during the annual survey with pressure sores. The incontinence measures indicate the percentage of residents with bladder or bowel incontinence at the time of the survey.

Table 1
Changes Over Time in Facility Characteristics (1985-2015)

Year	1985, Mean (CI)	1995, % or Mean (SD)	2005, % or Mean (SD)	2015, % or Mean (SD)
Number of nursing homes, n	19,068*	16,824	16,091	15,686
Percentage dual (Medicare + Medicaid) certified	33.3 (28.9, 37.8)	78.6	93.4	97.1
Percentage member of a chain		51.24	52.43	56.81
Percentage for-profit	75.0 (70.9, 79.1)	66.4	66.0	69.1
Percentage with Alzheimer's Unit		11.2	18.2	15.2
Average number of beds		100.84 (67.93)	104.97 (65.37)	106.13 (61.31)
Percentage with 3-49 beds	33.7 (26.8, 41.0)	18.8	14.9	12.9
Percentage with 50-99 beds	32.4 (28.0, 36.8)	36.0	36.3	37.1
Percentage with 100-199 beds	27.8 (24.2, 31.5)	38.5	42.2	44.0
Percentage with ≥200 beds	6.1 (5.1, 7.2)	6.8	6.5	6.0
Average occupancy rate		87.14 (16.41)	84.43 (15.14)	81.19 (15.79)

CI, confidence interval; SD, standard deviation.
*Weighted number of facilities.
Source: The 1985 National Nursing Home Survey and the 1995, 2005, and 2015 Online Survey Certification and Reporting/Certification and Survey Provider Enhanced Reporting Data.

Analyses

Univariate analyses of the above variables were completed using Stata, version 14 (StataCorp, College Station, TX). Data from the NNHS were weighted using the facility, bed, and current resident weights provided. OSCAR/CASPER and LTCFocUS data are available at the facility level. Facility-level variables are averaged for each study year. We do not include inferential statistics in this article because we are presenting data for the entire population of NHs in the United States for the majority of years.

Results

Facility Characteristics

In the past 30 years, the NH industry has decreased in size, from 19,068 facilities in 1985 to 15,686 in 2016 (Table 1). There has also been an increase in the percentage of facilities that are nonprofit (25% in 1985 and 31% in 2015) and that are dually certified by both Medicare and Medicaid (33% in 1985 and up to 97% 2015). Between 1995 and 2015, chain membership increased from 51% to 57%, the percentage of facilities with an Alzheimer's special care unit increased from 11% to 15%, and the overall NH occupancy rates declined from 87% to 81%.

Resident Composition

The population that NHs serve has changed over the last 30 years (Table 2). Data from the NNHS and LTCFocUS suggest that although the average age of residents has remained constant, the percentage of residents who are racial and ethnic minorities has increased from 7.8% in 1985 to 20.7% in 2015. The average percentage of females decreased from 72% of residents in 1985 to 67% in 2015. The prevalence of long-stay residents within NHs has remained stable at 69% of all residents over this time period. However, the percentage of residents admitted from the hospital increased from 67% in 2000 to 85% in 2015. There has also been a shift of payer types over time (Figure 1). Between 1992 and 2015, the average percentage of residents with Medicaid as a primary payer decreased from 64% to 58%, whereas the average percentage of residents with Medicare as the primary payer rose from 9% to 15%.

Resident physical and cognitive function has decreased over the years (Table 3). According to LTCFocUS data, the average ADL dependency score among NH residents increased slightly, from 15 to 17, between 2000 and 2015. According to NNHS and OSCAR/CASPER data, residents who required assistance in bathing increased from a national average of 89% in 1985 to an average facility average of 96% in 2015. The same trend is demonstrated by the increased share of residents who need assistance with the other ADL from 1985 to 2015: assistance with dressing rose from 74% to 92%, assistance with transferring from 60% to 85%, assistance with toileting from 49% to 88%, and assisting with eating increased from 38% to 56%. However, there was a decrease in the percentage of residents who were bed-bound from 6% in 1985 to 4% in 2015, whereas being chair bound rose from 39% to 64%. The percentage of residents with dementia increased from an average of 39% in 1995 to an average of 45% across the facilities in 2015.

The share of residents with psychiatric diagnoses has increased over the years, as has the use of psychotropic medications. According to the OSCAR/CASPER data, there was an almost 3-fold increase in the share of residents with a psychiatric diagnosis, from 11% in 1995 to 31% by 2015. Between 1985 and 2015, the average percentage of

Table 2
Changes Over Time in Resident Demographics, Length of Stay, and Admission Source (1985-2015)

Year	1985, Mean (CI) (n = 1,489,508*)	2000, Mean (SD) (n = 16,824)	2005, Mean (SD) (n = 16,091)	2015, Mean (SD) (n = 15,686)
Percentage female	71.6 (70.3, 73.0)	72.1 (13.8)	70.9 (14.0)	66.7 (13.04)
Percentage black	7.0 (6.2, 7.8)	9.9 (17.8)	10.9 (18.5)	11.6 (18.0)
Percentage Hispanic	2.8 (2.3, 3.2)	2.9 (9.1)	3.4 (9.8)	4.5 (11.3)
Percentage white	92.2 (91.4, 93.0)	85.6 (21.3)	83.7 (22.6)	79.3 (24.0)
Average age, y	79.61 (79.21, 80)	80.95 (7.11)	80.15 (7.68)	79.71 (7.34)
Percentage long stay		69.3 (22.6)	70.6 (19.3)	68.6 (17.0)
Percentage admitted from the hospital		66.5 (22.9)	72.8 (21.5)	84.7 (17.2)

CI, confidence interval; SD, standard deviation.
NNHS data represent the weighted national averages, whereas LTCFocUS data represent the average of facility averages.
*Weighted number of residents.
Source: The 1985 National Nursing Home Survey(NNHS) and Brown University's LTCFocUS Data for 2000, 2005, and 2015.

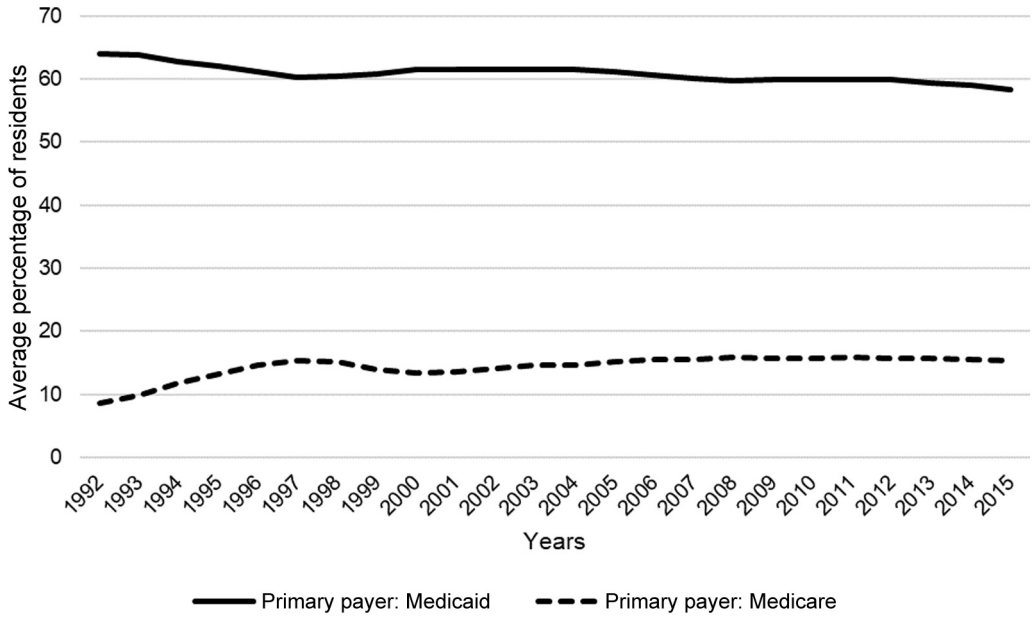

Fig. 1. Primary payment source using OSCAR/CASPER Data (1992-2015).

residents with schizophrenia increased from 6% to 11%. The percentages of residents receiving antianxiety, antidepressant, and antipsychotic medications in 1995 were 15%, 20%, and 16%, respectively, and by 2015 increased to 23%, 49%, and 20%, respectively.

Quality of Care

The average direct care staffing hours have increased over time, with the greatest increases observed among CNAs (see Table 4). Overall, quality process measures have also improved since the passage of OBRA 1987. Notably, the average proportion of residents being physically restrained decreased dramatically from 19% to 1%, and the percentage of residents receiving antipsychotic medications inappropriately, as a chemical restraint, decreased from 16% in 2000 to 12% in 2015, although there was a peak of 22% in 2005. However, there was not much change in the proportion of facilities cited for medication errors over this time period.

Quality outcome measures also improved over time. The proportion of residents with pressure ulcers decreased from 8% to 6%. Lastly, congruent with increased need for assistance, bowel and bladder incontinence increased from 42% to 44% and 49% to 62%, respectively.

Table 3
Changes Over Time in Resident Function, Mental Health, and Medication Use (1985-2015)

Year	1985, % (CI) (n = 1,489,508)*	1995/2000†, Mean (SD) (n = 16,824)	2005, Mean (SD) (n = 16,091)	2015, Mean (SD) (n = 15,686)
Physical and cognitive function				
Average Activities of Daily Living (ADL) Scale score†		15.26 (3.47)	15.60 (3.32)	16.87 (2.62)
Percentage of residents bed bound	6.5 (5.8, 7.2)	6.6 (9.9)	4.3 (7.4)	3.7 (6.9)
Percentage of residents chair bound	39.5 (38.1, 40.9)	48.1 (21.3)	55.1 (21.2)	64.3 (21.4)
Percentage of residents needing assistance with early-loss ADL				
Dressing	74.2 (72.8, 75.5)	86.6 (12.4)	88.2 (11.7)	91.8 (10.9)
Bathing	89.2 (88.1, 90.2)	94.2 (10.1)	95.4 (9.2)	96.5 (8.5)
Percentage of residents needing assistance with middle-loss ADL				
Transfer	60.2 (58.8, 61.7)	72.7 (16.5)	77.3 (15.4)	85.5 (14.7)
Toileting	49.2 (47.7, 50.6)	76.6 (15.0)	81.5 (13.9)	88.1 (13.0)
Percentage of residents needing assistance with late-loss ADL				
Eating	37.7 (36.3, 39.1)	53.0 (22.2)	49.4 (21.9)	56.5 (28.9)
Percentage of residents with dementia	43.3 (41.9, 44.8)	39.0 (20.0)	45.2 (19.4)	45.3 (18.4)
Mental health and medication use				
Percentage of residents with psychiatric diagnosis		11.2 (13.9)	19.8 (17.2)	31.4 (19.5)
Percentage of residents with schizophrenia†	5.7 (5.0, 6.4)	6.1 (9.9)	7.7 (11.0)	10.4 (13.0)
Percentage of residents receiving antianxiety medications		14.6 (10.2)	17.6 (10.3)	23.0 (11.6)
Percentage of residents receiving antidepressant medications		19.5 (10.9)	45.8 (14.3)	48.7 (14.5)
Percentage of residents receiving antipsychotic medication		16.0 (13.1)	26.0 (14.7)	20.1 (14.5)

CI, confidence interval; SD, standard deviation.
NNHS data represent the national averages, whereas OSCAR data represent the average of facility averages. The average ADL score is based on 7 ADL ranges from 0 to 28, where 0 = total independence and 28 = total dependence. The Average Acuity Index includes ADL and special treatment measures.[9]
*Weighted number of residents.
†These data are from the 2000, 2005, and 2015 LTCFocUs instead of the OSCAR/CASPER data.
Source: The 1985 National Nursing Home Survey (NNHS), the 1995, 2005, and 2015 Online Survey Certification and Reporting/Certification and Survey Provider Enhanced Reporting Data(OSCAR/CASPER), and the Brown University's LTCFocUS Data for 2000, 2005, and 2015.

Table 4
Changes Over Time in Quality Indicators (1995-2015)

Year	1995/2000*, Mean (SD) (n = 16,824)	2005, Mean (SD) (n = 16,091)	2015, Mean (SD) (n = 15,686)
Structure (staffing)			
CNA hours per resident day	2.26 (1.73)	2.30 (1.15)	2.42 (1.05)
LPN hours per resident day	0.87 (1.49)	0.84 (0.81)	0.88 (0.73)
RN hours per resident day	0.66 (1.64)	0.45 (0.86)	0.58 (0.87)
Direct care hours per resident day	3.39 (2.08)	3.48 (1.56)	3.79 (1.42)
Process			
Percentage of residents restrained	18.6 (17.2)	6.9 (8.7)	1.4 (4.9)
Percentage of residents receiving tube feeding	6.3 (8.5)	6.0 (8.4)	4.7 (8.2)
Percentage of residents with a catheter	8.3 (9.5)	7.0 (7.0)	5.9 (5.3)
Percentage of residents receiving inappropriate antipsychotic medication*	16.4 (9.4)	21.9 (10.2)	12.4 (7.6)
Percentage of facilities cited for medication errors ≥5%	1.5	1.8	1.7
Outcome			
Percentage of residents with pressure ulcers	7.6 (8.0)	7.4 (6.0)	6.2 (5.1)
Percentage of residents with bowel incontinence	41.8 (19.1)	42.9 (18.0)	43.9 (18.4)
Percentage of residents with bladder incontinence	49.3 (18.5)	53.5 (17.4)	62.1 (18.2)

CNA, certified nursing aide; LPN, licensed professional nurse; RN, registered nurse; SD, standard deviation.
*These data are from the 2000, 2005, and 2015 LTCFocUs instead of the OSCAR/CASPER Data.
Source: The 1995, 2005, and 2015 Online Survey Certification and Reporting/Certification and Survey Provider Enhanced Reporting Data (OSCAR/CASPER), and the 2000, 2005, and 2015 Brown University LTCFocUS Data.

Discussion

Within this 30-year period, there were facility, resident, and quality of care changes that can be linked to regulations adopted through the OBRA 1987 and other policy shifts in the long-term care sector.

Certification

Over the last 30 years, we witnessed a change in NH certification. This change is consistent with the OBRA 1987 requirement for NHs to be certified and meet the federal participation requirements in order to receive Medicaid and Medicare payments.[11] Previously, Medicare-certified facilities had more stringent requirements, but seeing that the majority of government spending came from Medicaid, OBRA 1987 stipulated that all Medicaid-certified facilities met a set of standards that were similar to that of Medicare.[1] Additionally, noting Medicare's generous reimbursement for skilled care, many Medicaid-only NHs became dually certified in both Medicare and Medicaid.[12] These policy and financing incentives likely contributed to the increase in the proportion of facilities that were dually certified during this time period.

Changing Demand and Supply, and Lower Occupancy

Concurrent with shifting US demographics (eg, an aging and increasingly diverse population), NHs in the last 30 years have witnessed increases in the proportion of minorities and decreases in the proportion of white residents. Recognizing the aging population, the long-term care market began to appear more lucrative and attracted a greater number of investors to NH operations.[13] This is evidenced by the percentage of NHs that were owned and operated by a chain. Stevenson, Grabowski, and Coots (2006) posit that chain facilities increased because of the interplay of certificate of need laws and resulting acquisitions.

Despite the aging of the population, there was a decrease in the number of NHs and facility occupancy rates during this time period. This decrease in NH supply and occupancy is likely attributable to the rise of community options such as assisted living and other HCBS.[14,15] In 2000, Medicaid spent about 27% of its total Medicaid long-term services and supports expenditures on HCBS and 73% on institutional care; by 2016, 57% of the expenditures were for HCBS and 43% for NH care.[6] It can be difficult to quantify the increase in community-based services due to data challenges; however, the National Survey of Resident Care Facilities identified approximately 31,100 residential facilities in 2010 and researchers have suggested a continued growth in the market.[16–18] The growth of long-term care alternatives allows individuals to remain in their homes and communities longer, in many cases delaying NH placement or diverting it altogether.[19–23] These trends may also explain some of the reasons behind the increase in functional impairment among NH residents over this time period.

Another potential explanation for the increase in functional impairment witnessed over this 30-year period may be the increase in post-acute, rehabilitative care provided in NHs. Recognizing the profitability associated with providing Medicare-reimbursed services,[24] NHs began to accept more post-acute care patients, with a large number of NHs choosing to specialize in the care of post-acute patients.[12,25] This shift in the orientation of NHs over this time period, from providing typically long-term custodial care to post-acute, rehabilitative care, may contribute to the increase in resident acuity witnessed in this study. It is evident from our findings that there is an increased percentage of residents being admitted directly from the hospital, presumably for post-acute care, which may contribute to higher levels of functional impairment as residents may be leaving hospitals "quicker and sicker."[26,27]

Quality Improvement

Despite higher resident levels of need, NH quality appears to have improved over time. Our data show modest gains in quality indicators between 1995 and 2015. The literature around drivers of quality improvement in NHs is vast and includes mechanisms such as NH ownership, nurse staffing, public reporting, and quality improvement initiatives. The quality improvement that we witnessed during this time period could have been attributable to the increase in nonprofit NHs, which have consistently shown to have higher quality ratings.[13] Quality improvement could also be directly related to the increase in nursing hours witnessed over this time period. OBRA 1987 improved the standards for nursing hours, and we observed these increases over time. Although it is possible that the increase in nursing hours may be in direct response to increasing need among residents, prior research has concluded that increasing nursing hours improves patient outcomes.[28–30] It is also plausible that new inspection, survey, enforcement efforts, and public reporting prompted improvements in quality

measures.[1,31] Although it can be argued that NHs still have room to improve in their quality indicators, it is important to note that despite an increasingly vulnerable and higher need population, we still observe quality gains among NHs during this time period.

One of the direct effects of OBRA 1987 was a substantial decrease in the use of physical restraints. Physical restraints were initially used on residents with serious mental illness to manage behaviors, but began to be used more widely on residents with behavioral symptoms, including residents with dementia.[32] Prior research indicates that physical restraints are associated with worse outcomes for residents, such as increased depression, less social engagement among NH residents,[33–35] reduced muscle strength,[33] and pressure ulcers.[33,34,36] Parts of OBRA 1987 focused directly on the residents' rights to be free from all restraints. Unfortunately, decreases in physical restraints were coupled with initial increases in chemical restraint use, such as inappropriate antipsychotic use. Antipsychotic medications increase the risk of falls[37] and death.[38,39] In 2005, the FDA released a Black Box warning to decrease the use of antipsychotics among older adults.[40] This warning is consistent with the 2005 peak in antipsychotic use that is present in our data. In 2011, CMS launched a national partnership to further reduce inappropriate antipsychotic use, which has been largely successful.[41] With the increase in dementia residents and initiatives to improve dementia care in NHs, there was a simultaneous increase in Alzheimer's SCUs, with a peak in the percentage of facilities with an Alzheimer's SCU in 2005. Literature suggests that residents within facilities with SCUs have significantly more challenging behaviors and have increased risk for chemical restraint use.[42,43] The presence of these units may also account for the increased resident impairment.

It is also important to note the dramatic increase in residents with serious mental illnesses (SMI), as this could be a direct result of state psychiatric facilities closures in the 1960s and 1970s. The increase in the SMI population creates a new and increased burden for NHs and their staff that may negatively affect the quality of care that NHs are able to provide.[44,45]

Despite the success of several prompted voiding interventions,[46,47] we observed increases into the share of NH residents experiencing incontinence over the past 30 years, potentially reflective of the increasing needs of the NH population. Prompting toileting interventions can be labor intensive, and it is often more convenient to diaper a resident than toilet.[48] More work is needed in this important quality of life area.

Limitations

This work provides a high-level look at national trends in NH characteristics, resident composition, and quality measures. Data are averaged across all facilities for the available study years. We do not have access to annual data available between 1986 and 1994, and because of the facility-level nature of our data we are unable to summarize resident-level changes over time. For example, it would be interesting to examine changes in acuity, separately for long-stay vs short-stay residents, or changes in residents' lengths of stay. This would help us understand if the increase in acuity over time is due to an increased focus on post-acute care, or attributable to higher levels of acuity among long-term residents who may delay entry into NHs through home- and community-based alternatives. Future work in this area would be beneficial to understanding additional impacts of OBRA on the long-term care industry as a whole.

Conclusions and Implications

Overall, OBRA 1987 is positively associated with the quality of care improvements in NHs despite increasing impairment of NH residents. OBRA 1987 was also successful in implementing and enforcing the MDS resident assessment survey, and without that this research would not be possible. Because of the aging-in-place movement, we are seeing lower occupancy rates in NHs. Older adults without financial resources, disproportionality minority older adults, are becoming an increasing proportion of NH residents, as they may not be able to as readily access these care alternatives. Current and future policies should focus on expanding equitable access to the remaining long-term care services and supports in the continuum of care, particularly given the policies and initiatives focused on decreasing NH utilization through support of home and community based alternatives.[49] Although NHs continue to focus more on short-stay post-acute care residents and long-stay residents with dementia, more work will need to be done in community-based settings to ensure the highest quality care and life. Improving quality is also about improving equity, and it is important for future work to examine access to quality care for our most vulnerable older adults who are sometimes triply and doubly vulnerable because of their cognitive status, race, and/or socioeconomic position. As our work shows, much of the quality progress made in NHs has been because of regulation and oversight over the years. The same level of oversight does not exist for all community alternatives, but the evidence presented here is indicative of effective practices.

Future research is also needed to understand whether these improvements in quality over the past 30 years have been equitable on the basis of race, socioeconomic status, gender, and geography. In sum, our findings document the 30-year history of NHs since the passage of the seminal legislation: OBRA 1987. As we look toward the future of long-term care, it is important that we reflect on the past.

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Hospital Transfer Rates Among US Nursing Home Residents With Advanced Illness Before and After Initiatives to Reduce Hospitalizations

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IMPORTANCE Hospital transfers among nursing home residents in the United States who have been diagnosed with advanced illnesses and have limited life expectancy are often burdensome, costly, and of little clinical benefit. National initiatives, introduced since 2012, have focused on reducing such hospitalizations, but little is known about the consequences of these initiatives in this population.

OBJECTIVE To investigate the change in hospital transfer rates among nursing home residents with advanced illnesses, such as dementia, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD), from 2011 to 2017—before and after the introduction of national initiatives to reduce hospitalizations.

DESIGN, SETTING, AND PARTICIPANTS In this cross-sectional study, nationwide Minimum Data Set (MDS) assessments from January 1, 2011, to December 31, 2016 (with the follow-up for transfer rates until December 31, 2017), were used to identify annual inception cohorts of long-stay (>100 days) nursing home residents who had recently progressed to the advanced stages of dementia, CHF, or COPD. The data were analyzed from October 24, 2018, to October 3, 2019.

MAIN OUTCOMES AND MEASURES The number of hospital transfers (hospitalizations, observation stays, and emergency department visits) per person-year alive was calculated from the MDS assessment from the date when residents first met the criteria for advanced illness up to 12 months afterward using Medicare claims from 2011 to 2017. Transfer rates for all causes, potentially avoidable conditions (sepsis, pneumonia, dehydration, urinary tract infections, CHF, and COPD), and serious bone fractures (pelvis, hip, wrist, ankle, and long bones of arms or legs) were investigated. Hospice enrollment and mortality were also ascertained.

RESULTS The proportions of residents in the 2011 and 2016 cohorts who underwent any hospital transfer were 56.1% and 45.4% of those with advanced dementia, 77.6% and 69.5% of those with CHF, and 76.2% and 67.2% of those with COPD. The mean (SD) number of transfers per person-year alive for potentially avoidable conditions was higher in the 2011 cohort vs 2016 cohort: advanced dementia, 2.4 (14.0) vs 1.6 (11.2) (adjusted risk ratio [aRR], 0.73; 95% CI, 0.65-0.81); CHF, 8.5 (32.0) vs 6.7 (26.8) (aRR, 0.72; 95% CI, 0.65-0.81); and COPD, 7.8 (30.9) vs 5.5 (24.8) (aRR, 0.64; 95% CI, 0.57-0.72). Transfers for bone fractures remained unchanged, and mortality did not increase. Hospice enrollment was low across all illness groups and years (range, 23%-30%).

CONCLUSIONS AND RELEVANCE The findings of this study suggest that concurrent with new initiatives aimed at reducing hospitalizations, hospital transfers declined between 2011 and 2017 among nursing home residents with advanced illnesses without increased mortality rates. Opportunities remain to further reduce unnecessary hospital transfers in this population and improve goal-directed care for those residents who opt to forgo hospitalization.

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Supplemental content

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A central objective of the Patient Protection and Affordable Care Act (ACA) of 2010 was to transform health care by ensuring that patients receive high-value, effective care.[1] Toward this objective, there has been particular focus on reducing potentially avoidable hospital transfers from the long-term care setting. The opportunity and need to reduce avoidable hospitalizations are greatest among people with advanced chronic illnesses[2] for whom the burdens of hospitalization often outweigh the benefits.[3-5] Little is currently known about how hospital transfer rates have changed among this population since broad initiatives were introduced.

Approximately 50% of nursing home residents experience 1 or more hospitalization in their last year of life.[6] At least half of these hospitalizations are estimated to be potentially avoidable because the acute condition could be managed effectively in the nursing home or the hospital-level care is not aligned with patient preferences.[7-11] Decisions regarding hospital transfers should be guided by the primary goal of care (eg, prolongation of life vs comfort), which is comfort for most nursing home residents with advanced illness.[12-15] With rare exceptions (eg, serious bone fractures), hospitalization seldom promotes the goal of comfort.

Since 2012, several new approaches have emerged from the ACA to try to reduce hospital transfers of nursing home residents. Care models that enhance the nursing home's on-site capability to manage specific targeted conditions (sepsis, pneumonia, urinary tract infections, dehydration, congestive heart failure [CHF], and chronic obstructive pulmonary disease [COPD]) have shown promise through the quality initiative program of the Centers for Medicare & Medicaid Services (CMS) to reduce avoidable hospitalizations.[9,10] Evaluation of the initiative's first phase in 7 states demonstrated estimated net reductions in 2015 of 2.2% to 9.3% in the probability of an all-cause hospitalization and 1.4% to 7.2% in the probability of a potentially avoidable hospitalization for participating residents compared with comparison groups.[1] Alternative payment models, such as accountable care organizations and bundled payments, also create financial incentives for nursing homes to reduce hospital transfers.[16] The Hospital Readmissions Reduction Program (HRRP) implemented financial penalties for hospitals with excess readmissions for target conditions including pneumonia, CHF, and COPD.[17,18] These concurrent initiatives raised national awareness and forged collaborations around transitional care to avoid unnecessary hospitalizations.[19] The consequences of such initiatives on hospital transfer rates, specifically among residents with advanced illnesses, have not been reported, to our knowledge.

The present study used Minimum Data Set (MDS) assessments linked to Medicare data to examine the national trends of hospital transfer rates from 2011 to 2017 among long-stay, fee-for-service nursing home residents with advanced dementia, CHF, or COPD. We specifically examined transfers for conditions that were deemed to be potentially avoidable and were the target of recent policy initiatives. For comparison, we also examined hospital transfer rates for serious bone fractures, which we hypothesized would be less affected by such initiatives. Finally, we assessed mortality and hospice enrollment rates.

Key Points

Question How did the hospital transfer rates change between 2011 and 2017 among nursing home residents diagnosed with advanced illness and limited life expectancy before and after the introduction of national initiatives to reduce hospitalizations?

Findings In this US nationwide cross-sectional study of 6 cohorts of nursing home residents with advanced illness, such as dementia, congestive heart failure, and chronic obstructive pulmonary disease, although hospital transfers for all causes and for potentially avoidable conditions were common, such transfers were found to have declined considerably from 2011 to 2017, and concurrent hospice use was low across all cohorts.

Meaning The findings of this study suggest that hospital transfer rates among nursing home residents with advanced illness declined from 2011 to 2017 and that opportunities remain to reduce unnecessary hospital transfers among residents with advanced illness.

Methods

Advanced Illness Cohorts

In this cross-sectional study, the MDS version 3.0 assessments[20] from federally licensed nursing homes in the United States were used from January 1, 2011, to December 31, 2016, to construct annual inception cohorts of long-stay residents (ie, >100 days) aged 65 years or older who were diagnosed with advanced dementia, CHF, or COPD. The MDS version 3.0 is a standardized, comprehensive assessment conducted on all nursing home residents at admission and at routine intervals (eg, quarterly) and was implemented in 2011.[20] Key differences between MDS 3.0 and MDS 2.0 precluded us from using MDS before 2011.[21] To construct these cohorts, we identified residents from the first MDS assessment at which they met the full criteria for advanced dementia, CHF, or COPD (hereafter, baseline assessment) in each calendar year. Residents may have had the illness, such as CHF, on a prior MDS assessment but were not included in the cohort until they first met the criteria for advanced disease, as described below. Residents had to be continuously enrolled in the Medicare Parts A and B fee-for-service program for up to 12 months after their baseline assessment and could belong to more than 1 advanced illness group. Residents enrolled in hospice at the baseline assessment were excluded. The institutional review board at Brown University approved this study under expedited review and waived informed consent under 45 CFR 46.116.

We defined advanced dementia, CHF, and COPD using criteria adapted from previous studies[5,22,23] using MDS to approximate hospice eligibility criteria, thus implying limited life expectancy. Advanced dementia criteria included the following: diagnosis of Alzheimer disease or other dementia, advanced cognitive impairment as defined by a score of 3 (moderate impairment) or 4 (severe impairment) on the Cognitive Function Scale,[24] and extensive or total assistance needed for eating and transferring. Advanced CHF was defined as follows: CHF diagnosis, shortness of breath while sitting or supine, and extensive or total assistance needed for transferring. Advanced COPD was

defined as follows: diagnosis of COPD (including emphysema and asthma), shortness of breath while sitting or supine, and extensive or total assistance needed for transferring.

Covariates

Age, sex, nonwhite race, dual-eligible status indicating beneficiaries qualifying for both Medicare and Medicaid, MDS 3.0 mortality risk score (MRS3),[25] and cohort year were ascertained from the baseline MDS assessment. The MRS3 (0-39) is a validated risk score based on demographic, clinical, and functional characteristics, with higher values indicating greater 30- and 60-day mortality risk. An MRS3 score of 8 or higher is associated with a 5.4 times increased odds of 30-day mortality compared with scores lower than 8.[25]

Outcomes

Residents were followed for up to 12 months from their baseline MDS assessment using Medicare claims from January 1, 2011, to December 31, 2017, to ascertain the occurrence of hospital transfers for all causes, potentially avoidable conditions, and serious bone fractures. Thus, person-time and outcomes spanned 2 calendar years (eg, for the 2016 cohort, outcomes were assessed in both 2016 and 2017). Hospital transfers included acute hospitalizations, observation stays, and emergency department (ED) visits. Hospitalizations were identified from the Medicare Provider Analysis and Review file.[26] Observation stays were defined as any outpatient facility claim for observation services using Healthcare Common Procedure Codes G0378-G0379,[27] *Current Procedural Terminology* codes 99217-99220,[28] or hospital outpatient revenue center code 0762. Emergency department visits were ascertained using outpatient facility claims with revenue center codes 0450-0459 or 0981, Healthcare Common Procedure Codes G0380-G0385, or carrier claims for ED services using *Current Procedural Terminology* codes 99281-99285. Observation stays that became admissions were considered to be hospitalizations. Emergency department visits that became hospitalizations or observation stays were classified accordingly.

Potentially avoidable transfers were identified using ambulatory care-sensitive conditions,[7-11] including sepsis, pneumonia, dehydration, urinary tract infections, heart failure, and COPD (including emphysema and asthma) (eTable 1 in the Supplement). These conditions account for 78% of the potentially avoidable hospitalizations among nursing home residents.[9] Serious bone fractures were examined as counterfactual conditions that usually result in hospital transfers regardless of existing policies and included fractures of the pelvis, hip, long bones of arms (humerus, ulna, and radius) and legs (femur, tibia, and fibula), wrists, and ankles (eTable 1 in the Supplement). We classified hospital transfers for these conditions using the claim's principal diagnosis. Mortality and hospice enrollment within 12 months after the baseline assessment were identified from the Medicare Master Beneficiary Summary File[29] and the 2011 to 2017 hospice claims, respectively.

Statistical Analysis

The data were analyzed from October 24, 2018, to October 3, 2019. Descriptive analyses were performed for resident characteristics and outcomes using means with SDs for continuous variables and proportions for categorical variables. Descriptive results were generated for each advanced illness group stratified by cohort year. Hospital transfers were further described by type (hospitalizations, observation stays, and ED visits) and by condition (all causes, potentially avoidable, and serious bone fractures). The proportion of potentially avoidable transfers attributable to specific diagnoses (eg, sepsis, pneumonia) were also calculated and presented graphically. Outliers defined as residents with all-cause hospital transfer rates exceeding 365 transfers per person-year alive across 12 months were removed (<1% of residents across all cohorts combined). Hospital transfer outcomes across 12 months were measured as the proportion of residents who experienced at least 1 transfer and the number of transfers per person-year alive. Mortality and hospice enrollment outcomes across 12 months were measured as the proportion of residents who experienced the event and the time to event. For all models, the main independent variable was the cohort year, with 2011 as the referent category. All models were adjusted for age, sex, nonwhite race, and MRS3 score. All models were fitted using generalized estimating equations to account for clustering within nursing homes and included an offset for log-transformed person-time.

Binary outcomes (any hospital transfers, hospice enrollment, and mortality) were analyzed using log-linked binomial models to estimate relative risk with cohort year. Zero-inflated Poisson regression models were used to analyze outcomes measured as number of transfers per person-year alive to allow for overdispersion owing to the high proportion of residents without a hospital transfer.[30] Adjusted risk ratios (aRRs) and 95% CIs were generated for these analyses. Finally, Cox proportional hazards regression models were used to analyze time-to-event outcomes (hospice enrollment, mortality) across 12 months of follow-up. In the hospice model, death without hospice was considered to be a competing risk. Adjusted hazard ratios and 95% CIs were estimated from these analyses. Analyses were performed using SAS, version 9.4 (SAS Institute Inc).

Results

Table 1 gives the characteristics of the nursing home residents by cohort year and advanced illness group. The 2011 cohort sizes were smaller for all illness groups compared with those of other years because residents had to be in the nursing home for at least 100 days and MDS data before 2011 were not used. Nonetheless, the overall distributions of age and sex were similar across cohort years within illness groups. Residents with advanced CHF (10.1-10.9) and COPD (9.0-9.6) generally had higher MRS3 scores (higher mortality risk) compared with residents with advanced dementia (7.5-8.4). All cohorts were predominately female, white, and dually eligible for Medicare and Medicaid.

Table 2 provides hospital transfer outcomes. All-cause hospital transfers were common in all illness groups across all years and were consistently lower for residents with advanced dementia compared with other groups. The most pronounced reduction in transfers occurred from the 2011 to 2012 cohort and

Table 1. Characteristics of Nursing Home Residents With Advanced Illness by Cohort Year[a]

Characteristic	Cohort Year[a]					
	2011[b]	2012	2013	2014	2015	2016
Advanced Dementia						
Residents, No.	18 178[b]	44 385	50 725	53 078	53 418	52 221
Follow-up, mean (SD), d	232.5 (146.0)	238.2 (143.6)	242.8 (143.0)	241.8 (142.4)	243.6 (142.7)	238.7 (143.5)
Age, mean (SD), y	85.0 (7.6)	85.4 (7.6)	85.6 (7.8)	85.8 (7.8)	85.9 (7.9)	85.8 (8.0)
Female, No. (%)	12 400 (68.2)	30 760 (69.3)	35 630 (70.2)	37 303 (70.3)	37 906 (71.0)	36 572 (70.0)
Nonwhite race, No. (%)	3196 (17.6)	7312 (16.5)	8140 (16.0)	8508 (16.0)	8467 (15.9)	8464 (16.2)
Dual eligible, No. (%)[c]	12 654 (69.6)	32 238 (72.6)	37 522 (74.0)	39 462 (74.3)	39 558 (74.1)	39 280 (75.2)
MRS3, mean (SD)[d]	8.4 (3.6)	8.1 (3.6)	7.9 (3.5)	7.7 (3.4)	7.6 (3.4)	7.5 (3.3)
Advanced Congestive Heart Failure						
Residents, No.	8866[b]	16 667	17 782	17 392	17 562	18 931
Follow-up, mean (SD), d alive	207.8 (149.3)	217.8 (148.1)	228.5 (146.7)	226.1 (146.1)	223.9 (148.0)	218.9 (149.5)
Age, mean (SD), y	84.2 (8.1)	84.5 (8.2)	84.5 (8.3)	84.5 (8.5)	84.5 (8.6)	84.3 (8.6)
Female, No. (%)	5994 (67.6)	11 484 (68.9)	12 247 (68.9)	11 999 (69.0)	12 183 (69.4)	12 865 (68.0)
Nonwhite race, No. (%)	1417 (16.0)	2429 (14.6)	2544 (14.3)	2454 (14.1)	2338 (13.3)	2812 (14.9)
Dual eligible, No. (%)[c]	6447 (73.1)	12 665 (76.0)	13 437 (75.6)	13 216 (76.0)	13 097 (74.6)	14 224 (75.1)
MRS3, mean (SD)[d]	10.7 (3.3)	10.9 (3.1)	10.8 (3.0)	10.5 (3.0)	10.7 (3.0)	10.1 (2.9)
Advanced Chronic Obstructive Pulmonary Disease						
Residents, No.	8467[b]	16 597	17 806	17 166	17 409	19 154
Follow-up, mean (SD), d alive	220.5 (148.3)	233.8 (144.8)	243.7 (143.3)	241.9 (142.7)	242.1 (143.9)	239.5 (144.8)
Age, mean (SD), y	82.8 (8.2)	83.1 (8.2)	83.1 (8.4)	83.2 (8.6)	83.1 (8.5)	83.1 (8.6)
Female, No. (%)	5584 (64.6)	10 818 (65.2)	11 788 (66.2)	11 303 (65.8)	11 573 (66.5)	12 668 (66.1)
Nonwhite race, No. (%)	1386 (16.0)	2422 (14.6)	2523 (14.2)	2441 (14.2)	2310 (13.3)	2775 (14.5)
Dual eligible, No. (%)[c]	6566 (75.9)	12 933 (77.9)	14 019 (78.7)	13 499 (78.6)	13 414 (77.1)	15 121 (78.9)
MRS3, mean (SD)[d]	9.6 (3.3)	9.6 (3.2)	9.6 (3.0)	9.4 (3.0)	9.3 (2.9)	9.0 (3.0)

Abbreviations: MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using MDS 3.0 assessments from 2011 to 2016.

[b] Cohort sizes from 2011 were smaller compared with those of other years because residents had to be in the nursing home for at least 100 days and MDS data before 2011 were not used.

[c] Beneficiaries who qualify for both Medicare and Medicaid benefits.

[d] MDS 3.0 mortality risk score, range 0-39; higher scores indicate higher risk of mortality.

then from the 2012 to 2013 cohort. Data showed no further reduction after 2013 and higher rates in 2016 than in 2015, particularly in the CHF and COPD cohorts. The adjusted proportions of residents who had at least 1 hospital transfer for any cause in the 2011 and 2016 cohorts were 56.1% and 45.4% for those with advanced dementia, 77.6% and 69.5% for those with CHF, and 76.2% and 67.2% for those with COPD. The mean (SD) number of hospital transfers per person-year alive for any cause was higher in the 2011 vs 2016 cohorts for nursing home residents with advanced dementia, 5.8 (22.7) vs 3.9 (17.9); CHF, 16.8 (43.9) vs 13.5 (38.9); and COPD, 15.6 (42.4) vs 11.2 (35.8). For each illness, the decrease in transfer rates between the 2011 and 2016 cohorts remained significant (advanced dementia [aRR, 0.72; 95% CI, 0.67-0.78]; CHF [aRR, 0.74; 95% CI, 0.68-0.80]; and COPD [aRR, 0.66; 95% CI, 0.61-0.72]) after adjustment for baseline characteristics. As demonstrated in **Figure 1**, reductions in hospital transfer rates over time were almost entirely attributable to declines in acute hospitalizations in each illness group.

Transfers for potentially avoidable conditions were common and decreased over time in each illness group in patterns similar to those of transfers for all causes (Table 2). The adjusted proportions of residents having at least 1 hospital transfer for a potentially avoidable condition in the 2011 and 2016 cohorts, respectively, were 26.5% and 20.4% for those with advanced dementia; 50.0% and 42.9% for those with CHF; and 49.2% and 40.7% for those with COPD. The mean (SD) number of hospital transfers per person-year alive for potentially avoidable conditions for the 2011 vs 2016 cohorts were 2.4 (14.0) vs 1.6 (11.2) (aRR, 0.73; 95% CI, 0.65-0.81) for those with advanced dementia; 8.5 (32.0) vs 6.7 (26.8) (aRR, 0.72; 95% CI, 0.65-0.81) for those with CHF; and 7.8 (30.9) vs 5.5 (24.8) (aRR, 0.64; 95% CI, 0.57-0.72) for those with COPD. Sepsis was the most frequent condition attributed to potentially avoidable transfers in all cohort years for all groups (**Figure 2**). The next most frequent conditions documented for potentially avoidable transfers were pneumonia and urinary tract infections for advanced dementia and CHF and pneumonia for both advanced CHF and COPD.

Hospital transfers for a primary diagnosis of serious bone fractures were relatively uncommon and, as hypothesized, remained unchanged for all advanced illness groups across all years (Table 2). **Table 3** gives the mortality and hospice enrollment outcomes. Hospice enrollment was low across all illness groups and years (range, 23%-30%). Mortality within 1 year exceeded 50% for all advanced illness groups across all years but did not increase over time in any illness group. Hospice use

Table 2. Hospital Transfer Outcomes Across 12 Months Among Nursing Home Residents With Advanced Illness by Cohort Year[a]

Outcome	Cohort Year[a] 2011	2012	2013	2014	2015	2016
Advanced Dementia						
Any transfer, adjusted % (95% CI)[b]						
All causes	56.1 (55.4-56.9)	51.1 (50.5-51.4)	45.9 (45.6-46.4)	45.1 (44.7-45.5)	44.5 (44.1-44.9)	45.4 (44.9-45.8)
Potentially avoidable[c]	26.5 (25.9-27.2)	23.2 (22.8-23.6)	20.0 (19.6-20.3)	19.7 (19.4-20.1)	19.5 (19.2-19.8)	20.4 (20.1-20.7)
Fractures[d]	2.4 (2.2-2.6)	2.3 (2.2-2.5)	2.3 (2.1-2.4)	2.3 (2.2-2.5)	2.4 (2.2-2.5)	2.4 (2.3-2.6)
Hospital transfers per person-year alive						
All causes, mean (SD)	5.8 (22.7)	4.1 (16.7)	3.3 (14.4)	3.1 (13.6)	3.2 (14.2)	3.9 (17.9)
Adjusted RR[b]	1 [Reference]	0.71 (0.66-0.77)	0.58 (0.54-0.62)	0.56 (0.52-0.60)	0.57 (0.53-0.62)	0.72 (0.67-0.78)
Potentially avoidable, mean (SD)[c]	2.4 (14.0)	1.6 (10.2)	1.2 (7.8)	1.2 (7.6)	1.2 (8.0)	1.6 (11.2)
Adjusted RR[b]	1 [Reference]	0.67 (0.60-0.75)	0.52 (0.47-0.58)	0.51 (0.46-0.57)	0.53 (0.48-0.59)	0.73 (0.65-0.81)
Fractures, mean (SD)[d]	0.06 (0.78)	0.06 (0.87)	0.05 (0.82)	0.06 (0.72)	0.07 (1.08)	0.08 (1.24)
Adjusted RR	1 [Reference]	0.98 (0.77-1.24)	0.85 (0.67-1.07)	0.93 (0.75-1.16)	1.03 (0.81-1.30)	1.28 (1.00-1.61)
Advanced Congestive Heart Failure						
Any transfer, adjusted % (95% CI)[b]						
All causes	77.6 (76.7-78.5)	69.3 (68.6-70.0)	63.6 (62.9-64.3)	63.2 (62.5-63.9)	64.7 (63.9-65.4)	69.5 (68.9-70.2)
Potentially avoidable[c]	50.0 (49.9-51.1)	41.5 (40.7-42.2)	36.4 (35.7-37.1)	36.6 (35.8-37.3)	38.1 (37.3-38.8)	42.9 (42.2-43.6)
Fractures[d]	2.0 (1.8-2.3)	1.9 (1.8-2.2)	2.0 (1.8-2.2)	2.1 (1.9-2.3)	2.0 (1.8-2.2)	2.0 (1.8-2.2)
Hospital transfers per person-year alive						
All causes, mean (SD)	16.8 (43.9)	11.1 (33.6)	8.0 (24.1)	8.0 (24.3)	9.6 (28.3)	13.5 (38.9)
Adjusted RR[b]	1 [Reference]	0.69 (0.64-0.75)	0.49 (0.45-0.53)	0.49 (0.45-0.53)	0.57 (0.53-0.62)	0.74 (0.68-0.80)
Potentially avoidable, mean (SD)[c]	8.5 (32.0)	5.2 (23.5)	3.5 (15.8)	3.4 (15.1)	4.5 (19.6)	6.7 (26.8)
Adjusted RR[b]	1 [Reference]	0.64 (0.58-0.72)	0.42 (0.38-0.47)	0.42 (0.38-0.47)	0.53 (0.48-0.59)	0.72 (0.65-0.81)
Fractures, mean (SD)[d]	0.08 (1.20)	0.08 (1.59)	0.08 (1.01)	0.07 (1.01)	0.07 (1.21)	0.90 (2.37)
Adjusted RR	1 [Reference]	0.99 (0.65-1.51)	0.86 (0.60-1.24)	0.84 (0.58-1.21)	0.82 (0.55-1.21)	1.02 (0.63-1.63)
Advanced Chronic Obstructive Pulmonary Disease						
Any transfer, adjusted % (95% CI)[b]						
All causes	76.2 (75.3-77.1)	69.1 (68.4-69.9)	63.3 (62.6-64.0)	63.1 (62.3-63.8)	63.9 (63.2-64.7)	67.2 (66.6-67.9)
Potentially avoidable[c]	49.2 (48.2-50.2)	41.2 (40.4-41.9)	35.9 (35.2-36.6)	36.0 (35.3-36.7)	37.2 (36.4-37.9)	40.7 (40.0-41.4)
Fractures[d]	2.3 (2.0-2.6)	2.2 (2.0-2.5)	2.3 (2.1-2.6)	2.4 (2.2-2.6)	2.2 (2.0-2.5)	2.2 (2.0-2.5)
Hospital transfers per person-year alive						
All causes, mean (SD)	15.6 (42.4)	9.9 (30.2)	7.3 (22.1)	7.7 (24.8)	8.6 (27.4)	11.2 (35.8)
Adjusted RR[b]	1 [Reference]	0.60 (0.55-0.65)	0.43 (0.39-0.46)	0.46 (0.41-0.49)	0.50 (0.46-0.55)	0.66 (0.61-0.72)
Potentially avoidable, mean (SD)[c]	7.8 (30.9)	4.6 (21.1)	3.1 (14.3)	3.2 (15.5)	3.8 (17.5)	5.5 (24.8)
Adjusted RR[b]	1 [Reference]	0.55 (0.49-0.62)	0.36 (0.32-0.41)	0.37 (0.33-0.42)	0.44 (0.39-0.49)	0.64 (0.57-0.72)
Fractures, mean (SD)[d]	0.09 (1.19)	0.07 (0.98)	0.08 (0.98)	0.09 (1.08)	0.07 (0.74)	0.95 (2.16)
Adjusted RR	1 [Reference]	0.79 (0.55-1.11)	0.82 (0.58-1.14)	0.88 (0.63-1.23)	0.69 (0.50-0.96)	.095 (0.63-1.46)

Abbreviations: COPD, chronic obstructive pulmonary disease; MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score; RR, relative risk.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using MDS assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify transfers occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and transfers were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, transfers were assessed in both 2016 and 2017).

[b] All models were adjusted for age, sex, nonwhite race, and MRS3 and included an offset for log(person-time).

[c] Transfers for primary diagnosis of sepsis, pneumonia, dehydration, urinary tract infections, heart failure, and COPD or asthma.

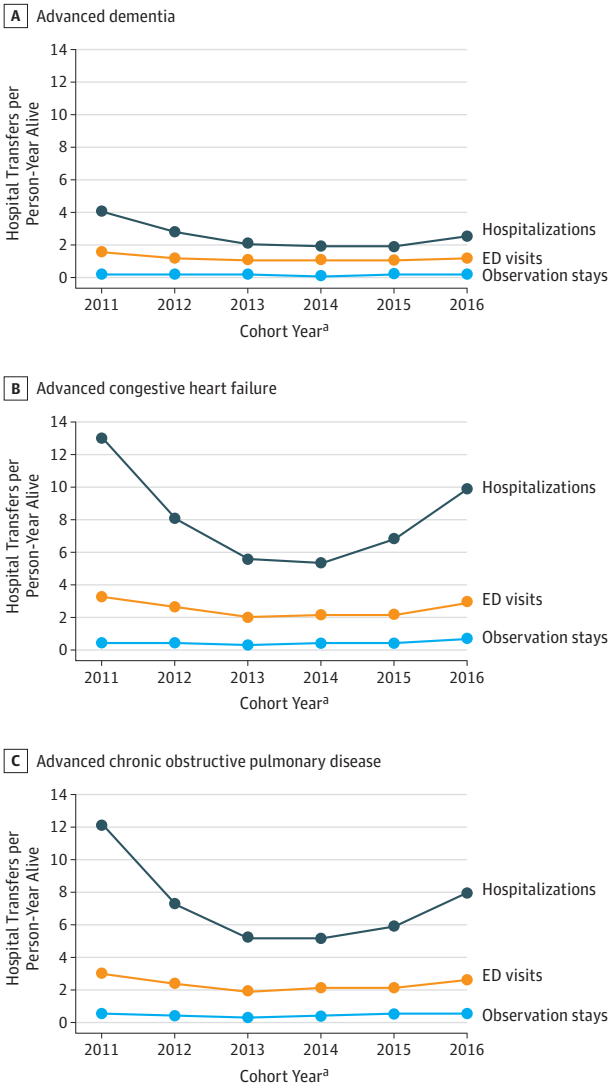
[d] Fractures of pelvis, hip, wrist, ankle, and long bone fractures of arms (humerus, ulna, and radius) and legs (femur, tibia, and fibula).

was low for all illnesses across all years but increased slightly for the 2016 cohort of residents with advanced dementia.

Discussion

We examined changes in national hospital transfer rates among long-stay nursing home residents with advanced dementia, CHF, and COPD from 2011 to 2017, a period during which national initiatives were introduced to reduce hospital transfers across care settings, including the long-term care setting. Transfers for all causes and potentially avoidable conditions declined for each advanced illness group during these years without adversely affecting mortality. This decline was almost entirely attributable to a reduction in hospitalizations rather than in observation stays or ED visits. In contrast, transfer rates for serious bone fractures, which are less likely to be associated with policy changes, remained stable. Sepsis and pneumonia were common reasons for potentially avoidable hospital transfers across all groups. Although the hospital transfer rates for all causes and potentially avoidable conditions declined, they remained common. In the 2016 cohorts, 45% of the residents with advanced

Figure 1. Transfer Rates for Hospitalizations, Emergency Department (ED) Visits, and Observation Stays for Illness Groups by Cohort Year



[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using Minimum Data Set assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify transfers occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and transfers were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, transfers were assessed in both 2016 and 2017).

dementia and roughly two-thirds of those with advanced CHF and COPD experienced at least 1 transfer despite the greater than 50% mortality rate across all groups. These observations, coupled with low hospice enrollment throughout all years, suggest that opportunities remain to further reduce hospital transfers and improve end-of-life care for nursing home residents with advanced illnesses.

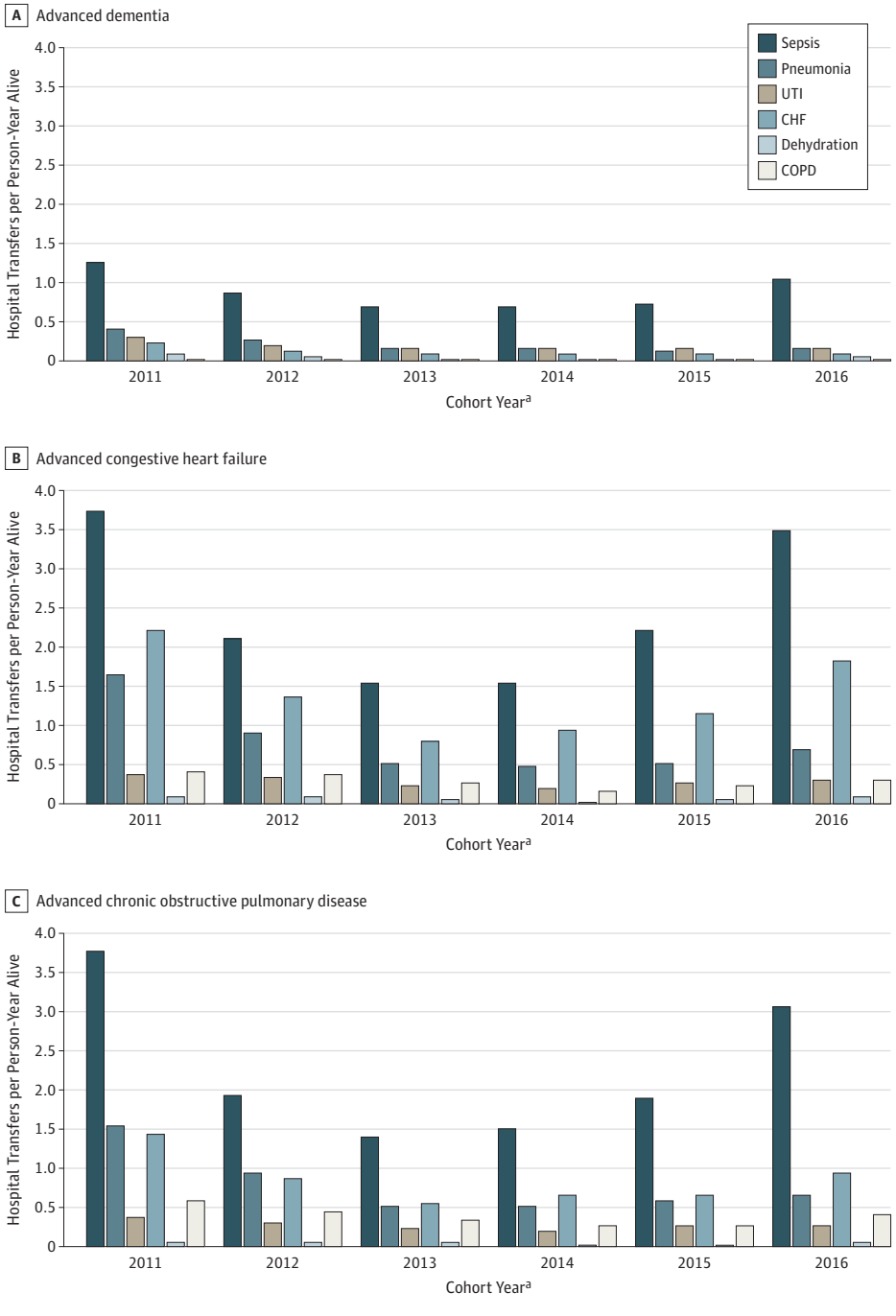
Although several studies describe changes in hospitalization rates in the United States in 2014 and 2015,[17,18,31-33] the present study focused on long-term care residents with advanced illness. The issue is particularly pertinent for this population because hospital transfers can be especially burdensome, of little clinical benefit, and distressing for family members.[3-5,34] Treatment decisions should be guided by patient preferences. Thus, if the decline in transfer rates observed in this study reflect, in part, decisions to avoid hospitalizations in favor of comfort-focused care, then such care should be available in the nursing home. High-quality palliative care is currently lacking in many US nursing homes.[35-37] Palliative care and hospice improve the quality of end-of-life care among nursing home residents, including reducing hospitalization rates.[32,36-39] Although we could not ascertain whether residents received palliative care outside the Medicare Hospice Benefit, we observed low rates of hospice enrollment and no concurrent uptake of hospice as hospital transfer rates declined. Given the increased scrutiny and federal audits of nursing homes with long hospice stays, the present study suggests that most residents with advanced dementia, CHF, and COPD are not receiving hospice care near the end of life.

Potentially avoidable hospital transfers among dual-eligible beneficiaries are key quality measures in long-term care and cost Medicare an estimated $2.6 billion annually.[9,40] Infections accounted for most potentially avoidable hospital transfers across advanced illness groups. Among residents with advanced CHF and COPD, exacerbations of these underlying conditions were also common reasons for transfers. Consequently, advance care planning among providers, residents, and family members presents a critical opportunity for informed decision-making about wishes for future hospitalizations in anticipation of expected clinical complications, and online resources are available to help guide these discussions.[41] Proxies of residents with advanced dementia should understand that recurrent infections are a hallmark of the end stage of the disease. Among residents with advanced illness for whom curative care remains aligned with their preferences, infections and cardiopulmonary decompensations can often be managed in the nursing home.[3,42-45] Of note, mortality did not increase across the cohort years in any group despite the decline in hospital transfers.

Programmatic initiatives, such as Interventions to Reduce Acute Care Transfers (INTERACT),[46] have been adopted widely to avoid unnecessary hospitalizations by improving the nursing home's capacity to provide on-site evaluation and management of acute changes through early recognition, monitoring, and staff training. Although a recent cluster randomized clinical trial of INTERACT demonstrated no effect on hospitalizations or ED visits, the trial highlighted the complexities of implementing and sustaining such interventions in nursing homes.[16]

This study's findings are consistent with those of studies documenting prominent declines in hospitalization and readmission rates between 2010 and 2012 after the enactment of the ACA and announcement of the HRRP, a Medicare value-based purchasing program that financially penalizes hospitals with excess readmissions for specific conditions.[17,18,47-49] Health care systems may have made systemic preparations in anticipation of the HRRP penalty phase in October 2012. Our findings also support the possible spillover effect of HRRP onto nonspecific conditions.[17,18,47,48,50] Consistent with other studies, we

Figure 2. Hospital Transfer Rates for Potentially Avoidable Conditions by Cohort Year



CHF indicates congestive heart failure; COPD, chronic obstructive pulmonary disease; and UTI, urinary tract infection.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using Minimum Data Set assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify transfers occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and transfers were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, transfers were assessed in both 2016 and 2017).

observed a leveling off of hospital transfer rates during 2014 to 2016.[17,18,47,48] Chhabra and colleagues[48] suggest that this pattern may reflect a floor effect—a point at which achieving additional reductions in rates becomes more difficult. Regression to the mean may also partly explain the marked decline observed in transfer rates compared with those in 2011.[33]

Several factors acting in parallel may contribute to the observed declines in potentially avoidable transfers. Increased attention and quality and performance improvement initiatives have targeted unnecessary hospital transfers. Recent studies demonstrate reductions in hospital readmissions for potentially avoidable conditions after implementation of the HRRP.[17,18] Although nursing homes were not subject to financial penalties under HRRP, many nursing homes across the United States adopted quality improvement programs, such as INTERACT, in anticipation of CMS quality assurance and performance improvement regulations.[46] In addition, nursing homes included in accountable care organizations or other preferred referral

Table 3. Mortality and Hospice Enrollment Across 12 Months Among Nursing Home Residents With Advanced Illness by Cohort Year[a]

Outcome	Cohort Year[a] 2011	2012	2013	2014	2015	2016
Advanced Dementia						
12-mo Mortality adjusted						
% (95% CI)[b]	52.8 (51.6-53.1)	51.8 (51.3-52.3)	50.5 (50.1-51.0)	52.0 (51.6-52.5)	51.0 (50.5-51.4)	53.3 (52.8-53.7)
HR (95% CI)[c]	1 [Reference]	0.97 (0.95-1.00)	0.94 (0.92-0.96)	0.98 (0.95-1.00)	0.95 (0.93-0.98)	1.02 (0.99-1.04)
Hospice in 12 mo adjusted						
% (95% CI)[b]	27.2 (26.5-27.8)	26.9 (26.5-27.4)	27.1 (26.7-27.4)	27.2 (26.9-27.6)	27.9 (27.6-28.3)	30.0 (29.6-30.4)
HR (95% CI)[d]	1 [Reference]	0.97 (0.94-1.01)	0.97 (0.94-1.00)	0.98 (0.95-1.02)	1.01 (0.98-1.04)	1.11 (1.08-1.15)
Advanced CHF						
12-mo Mortality adjusted						
% (95% CI)[b]	61.6 (60.6-62.6)	58.9 (58.1-59.6)	55.4 (54.7-56.2)	56.8 (56.0-57.5)	56.3 (55.5-57.0)	57.3 (56.6-58.0)
HR (95% CI)[c]	1 [Reference]	0.94 (0.90-0.99)	0.87 (0.83-0.91)	0.87 (0.84-0.90)	0.87 (0.84-0.90)	0.89 (0.86-0.92)
Hospice in 12 mo adjusted						
% (95% CI)[b]	27.9 (27.0-28.9)	27.1 (26.4-27.8)	25.8 (25.2-26.5)	26.9 (26.2-27.5)	27.4 (26.7-28.0)	29.9 (29.2-30.5)
HR (95% CI)[d]	1 [Reference]	0.94 (0.89-0.99)	0.87 (0.83-0.91)	0.91 (0.87-0.95)	0.93 (0.89-0.98)	1.03 (0.98-1.08)
Advanced COPD						
12-mo Mortality adjusted						
% (95% CI)[b]	57.8 (56.7-58.9)	53.6 (52.8-54.3)	49.9 (49.0-50.5)	51.3 (50.6-52.1)	50.7 (50.0-51.5)	52.2 (51.4-52.9)
HR (95% CI)[c]	1 [Reference]	0.88 (0.85-0.91)	0.80 (0.77-0.82)	0.82 (0.79-0.85)	0.82 (0.79-0.85)	0.85 (0.82-0.88)
Hospice in 12 mo adjusted						
% (95% CI)[b]	24.7 (23.8-25.6)	23.9 (23.2-24.6)	23.1 (22.5-24.0)	23.3 (22.7-24.0)	24.1 (23.4-24.7)	26.2 (25.6-26.9)
HR (95% CI)[d]	1 [Reference]	0.92 (0.87-0.97)	0.87 (0.82-0.91)	0.87 (0.83-0.92)	0.91 (0.86-0.95)	1.00 (0.95-1.05)

Abbreviations: CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; HR, hazard ratio; MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using MDS assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify outcomes occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and outcomes were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, outcomes were assessed in both 2016 and 2017).

[b] Adjusted for age, sex, nonwhite race, and MRS3 and offset for person-time.

[c] Adjusted for age, sex, nonwhite race, and MRS3. Mortality: HR <1.00 indicates lower rate of death relative to rate in 2011.

[d] Adjusted for age, sex, nonwhite race, and MRS3. Death was considered a competing risk. Hospice: HR <1.00 indicates lower rate of hospice enrollment relative to rate in 2011.

networks were further incentivized to reduce hospitalizations to remain in network.[16] The CMS is conducting demonstration projects to examine payment models that include value-based purchasing incentives as part of the initiative to reduce avoidable hospitalizations among nursing home residents.[10] The Skilled Nursing Facility (SNF) value-based purchasing program took effect in October 2018 to extend penalties for excess readmissions to SNFs; preliminary data suggest that 73% of SNFs face financial penalties after failing to achieve benchmarks.[51]

Previous research in long-term care settings has focused almost exclusively on potentially avoidable hospitalizations. The present study extends prior work to include all potentially avoidable hospital transfers, including ED visits and observation stays. We found that declines in all-cause hospital transfer rates were almost exclusively associated with reductions in acute hospitalizations, and the rates of observation stays remained low between 2011 and 2017. Thus, concerns that hospitals may shift admissions to observation stay status to avoid HRRP penalties[18] appear to be unfounded in this population. In addition, rates of decline were similar for all-cause and potentially avoidable transfers, suggesting that broader efforts are being made to reduce hospital transfers or that there is a spillover effect from the focus on potentially avoidable conditions. Although we observed reductions in potentially avoidable hospital transfers, several thousand nursing home residents with advanced illness continue to be transferred to hospitals near the end of life. We estimated 708 096 transfers for all-cause transfers across the 3 advanced illness cohorts from 2011 to 2017, of which 259 339 (36.8%) were potentially avoidable. Moreover, despite the initial reduction in potentially avoidable transfers from 39.1% in 2011 to 35.1% in 2013, the rate appears to have rebounded to 37.7% by 2016 (eTable 2 and eFigure in the Supplement).

Limitations

This study has limitations. The application of claims-based measures of potentially avoidable conditions to nursing home populations remains controversial because they do not capture the complex health status of frail, older nursing home residents with multimorbid conditions or the specific challenges of managing acute illnesses in this population and setting.[7,45] Moreover, insurance claims and MDS 3.0

assessments do not fully capture the circumstances leading to decisions for hospital transfer, including advance directives. Important drivers of decisions to transfer are associated with decisional processes and organizational factors, including communication, family preferences, and nursing home resources.[52-56] Furthermore, the principal diagnoses listed on hospital claims are assigned at discharge as the diagnosis that was chiefly responsible for the admission, whereas the diagnosis assigned to an ED visit or observation stay is based on more limited information.[57] However, we focused on long-term care residents with advanced illness for whom care decisions should align with values and goals of care and for whom the harms associated with hospital transfers usually outweigh possible benefits.[3-5]

Conclusions

Hospital transfer rates for all causes and for potentially avoidable causes declined in 2017 compared with 2011 for long-stay nursing home residents with advanced dementia, CHF, or COPD, with no increase in mortality. Reductions in potentially avoidable transfers are encouraging, yet many residents still experienced multiple transfers for infections and CHF or COPD exacerbations. These findings indicate important opportunities to improve care of nursing home residents with advanced illness through improvements in advance care planning, acute care management, and the delivery of high-quality palliative care.

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Letters

RESEARCH LETTER

Temporal Trends in the Numbers of Skilled Nursing Facility Specialists From 2007 Through 2014

Residents of nursing homes (NHs) comprise a medically complex and vulnerable population with many persons experiencing multiple comorbid conditions, frailty, and advanced dementia. Health care professionals such as physicians, nurse practitioners (NPs), and physician assistants (PAs) play an important role in managing their care. An Office of Inspector General Report[1] noted that specialization of health care professionals in NH care could potentially improve care through increased presence of health care professionals in NHs, enhanced knowledge in the care of patients with medically complex conditions, and better understanding of the regulatory environment. On the contrary, specialization in 1 setting of care could result in increased fragmentation of care, giving rise to concerns about medical errors and lack of care coordination. Little empirical research is available about the number of clinicians who primarily practice in NHs or the proportion of NH care delivered by these clinicians.[2] Using national Medicare Part B claims from 2007, 2010, and 2014, we characterized temporal trends in the number of physicians, NPs, and PAs concentrating their practice in the NH or skilled nursing facility (SNF) setting (ie, SNFists), the fraction of all NH and SNF claims generated by SNFists, and state variation in this phenomenon in 2014.

Editor's Note

Methods | The Medicare Part B Carrier File includes Evaluation and Management codes based on common sites of service: the nursing home, outpatient office, hospital, emergency department, a patient's home, and assisted living, custodial care facilities. Using Evaluation and Management codes from 20% of all Medicare Part B Carrier file claims from 2007, 2010, and 2014, we identified all physicians, NPs, and PAs who billed more than 90% of all their visits in the NH setting. The 90% threshold is consistent with a prior study of hospitalist care in the United States[3]; in a sensitivity analysis, we relaxed this threshold to 50%. Temporal trend comparisons for 2007, 2010, and 2014 were performed using variance-weighted least squares. We further characterized, in each state, the fraction of all outpatient visits in NHs that were accounted for by SNFists. An institutional review board waiver was obtained from Brown University.

Results | Between 2007 and 2014, the proportion of physicians ever billing in an NH decreased from 13.7% to 9.8% (test of trend, $P < .001$) while the number of physicians classified as SNFists increased by 48.2% (1496 vs 2225), increasing from 0.34% to 0.49% of all physicians (**Table**). The number of NPs or PAs classified as SNFists nearly doubled (1678 vs 3074). The proportion of NPs and PAs classified as SNFists remained stable because of increasing numbers of these clinicians. The proportion of all Evaluation and Management bills for care in an NH or SNF submitted by clinicians classified as SNFists increased from 11.6% to 14.3% among physicians (test of trend, $P < .001$) and from 10.4% to 17.2% among NPs and PAs (test of trend, $P < .001$). Between 2007 and 2014, the proportion of total SNF billing accounted for by SNFist clinicians increased from 22.0% to 31.5% (test of trend, $P < .001$). The SNFists' proportion of total NH billing varied by state, amounting to nearly 50% in Delaware, Hawaii, Tennessee, Connecticut, and Massachusetts. In a sensitivity analysis using a threshold of more than 50% of visits in the SNF, the number of physician SNFists increased from 2551 to 3529 and the number of NP or PA SNFists increased from 3267 to 5477.

Table. Physician, Nurse Practitioner, and Physician Assistant Billing in 2007, 2010, and 2014

Billing Category	2007	2010	2014
Physicians, No.	435 943	419 299	459 895
Ever billing in an SNF,[a] No. (%)	59 724 (13.7)	50 814 (12.1)	45 070 (9.8)
Billing ≥90% in an SNF,[a] No. (%)	1496 (0.34)	1697 (0.40)	2225 (0.49)
Nurse practitioners or physician assistants, No.	64 393	80 029	131 986
Ever billing in an SNF,[b] No. (%)	7528 (11.7)	8309 (10.4)	12 470 (9.5)
Billing ≥90% in an SNF,[b] No. (%)	1678 (2.6)	2031 (2.5)	3074 (2.3)
Evaluation and management code bills at SNF, No.	4 731 367	4 538 967	5 205 865
By physician billing ≥90% in an SNF,[c] No. (%)	550 425 (11.6)	584 952 (12.9)	747 106 (14.3)
By nurse practitioner or physician assistant billing ≥90% in an SNF,[c] No. (%)	49 145 (10.4)	581 235 (12.8)	895 830 (17.2)

Abbreviation: SNF, skilled nursing facility.

[a] For the physicians ever billing in an SNF or physicians billing 90% or more in an SNF, the denominator is physicians billing Medicare in that year.

[b] For nurse practitioner or physician assistant billing, the denominator is nurse practitioners or physician assistants billing Medicare in that year.

[c] The denominator for physicians, nurse practitioners, and physician assistants billing at 90% or more is the number of evaluation and management codes billed in a nursing home or SNF in the year 2007, 2010, or 2014.

Discussion | The care of frail and medically complex NH residents is increasingly performed by NPs and PAs who focus nearly exclusively in this site of care. In some states, SNFists accounted for nearly half of the total billing in the NH setting of care. Future research is needed to understand how this specialization of care affects not only care delivery but the overall experience of frail, elderly patients.

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Letters

RESEARCH LETTER

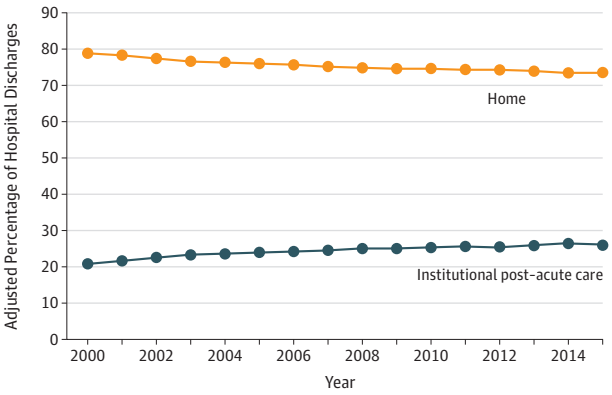
Trends in Post-Acute Care Use Among Medicare Beneficiaries: 2000 to 2015

Since Medicare's adoption of the inpatient prospective payment system in 1983, hospitals have sought ways to reduce costs, resulting in a decrease in hospital length of stay and an increase in the use of institutional post-acute care,[1] making it a major Medicare expenditure.[2] Since the Affordable Care Act passed in 2010, Medicare has implemented payment reforms designed to make hospitals and clinicians accountable for the cost and quality of care delivered. Examples include the Hospital Readmissions Reduction Program (implemented in 2012), accountable care organizations (2012), and bundled payments (2013). How these payment reforms affect the use of post-acute care is unknown.[3] The expense of post-acute care may diminish its use under cost-containment incentives.[4] Alternatively, pressure to reduce costs by reducing unnecessary readmissions may encourage its use. Our objective was to document recent trends in use of institutional post-acute care (including the 2 most common sites: skilled nursing facilities [SNFs] and inpatient rehabilitation facilities [IRFs]) and, simultaneously, hospital and post-acute care length of stay.

Methods | We used the 100% MedPAR file[5] to identify Medicare beneficiaries discharged alive from an acute care hospital between January 2000 and December 2015 (n = 199 069 327), excluding discharges younger than 65 years or discharged to hospice (n = 39 036 324 or 19.6%), enrolled in Medicare Advantage (n = 20 250 852 or 10.2%), or discharged to institutional settings other than SNF or IRF (eg, psychiatric hospital; n = 1 808 518 or 0.9%). We identified each discharge's first post-hospitalization destination (home vs institutional post-acute care) and the number of days in the hospital and post-acute care. We used multivariable regression to predict risk-adjusted annual outcomes adjusted for age, sex, race, and 31 Elixhauser comorbidities. We tested for the statistical significance of differences over time using *t* tests (2-tailed with an α of .05). All analyses were performed using Stata (StataCorp), version 15. This study was approved by the institutional review board of the University of Pennsylvania with a waiver of informed consent.

Results | Among 137 973 633 hospital discharges, 20.3% were discharged to SNFs and 3.7% were discharged to IRFs. The adjusted percentage of hospital discharges to post-acute care increased from 21.0% in 2000 to 26.3% in 2015 (increase of 5.36 percentage points [95% CI, 5.32 to 5.40]; *P* <.001), whereas the adjusted percentage of discharges home decreased from 79.0% in 2000 to 73.6% in 2015 (decrease of 5.36 percentage points [95% CI ,−5.40 to −5.32]; *P* <.001) (**Figure 1**).

Figure 1. Proportion of Medicare Beneficiaries Discharged to Institutional Post-Acute Care vs Discharged Home



Estimates are adjusted for patient age, sex, race, and Elixhauser comorbidities. The median number of hospital discharges to home per year was 6 664 718 (interquartile range [IQR], 5 768 018-7 367 173) and the median number of discharges to post–acute care per year was 2 151 959 (IQR, 1 978 709-2 199 801).

Among patients discharged to post-acute care, hospital length of stay decreased from 9.0 days in 2000 to 7.3 days in 2015 (decrease of 1.70 days [95% CI, −1.71 to −1.69]; *P* <.001) (**Figure 2**). Among patients discharged home, hospital stays decreased from 5.7 days in 2000 to 4.8 days in 2015 (decrease of −0.91 days [95% CI, −0.92 to −0.91]; *P* <.001). At the same time, length of stay in post-acute care increased from 21.7 days in 2000 to 25.7 days in 2014 (increase of 3.98 days [95% CI, 3.93 to 4.02]; *P* < .001) and then decreased to 25.1 days in 2015 (decrease of 0.54 days [95% CI, 0.50 to 0.59]; *P* < .001).

Discussion | The use of institutional post-acute care increased between 2000 and 2015 and was accompanied by increasing length of post-acute care stays through 2014. These trends did not appear to change when payment reform was implemented under the Affordable Care Act. SNFs (which accounted for 85% of institutional post-acute care) are paid per diem and thus may have strong incentives to maintain longer lengths of stay. This study was limited by the exclusion of Medicare Advantage enrollees. If policy incentives are to effectively reduce SNF length of stay, they might need to align SNF payment with the goal of reducing SNF use.

It is uncertain whether the use of post-acute care benefits patients. Despite its proliferation, there is little evidence that post-acute care improves key patient outcomes—preventing rehospitalizations or improving functional recovery. Further investigating how post-acute care affects patient outcomes is essential.

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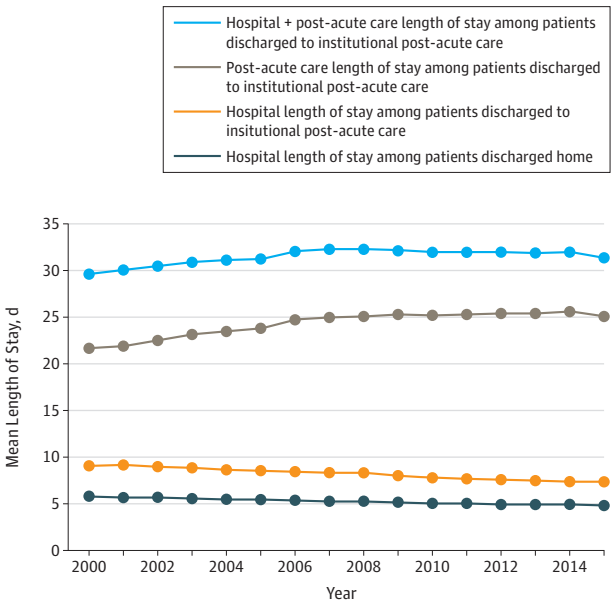
Figure 2. Mean Length of Stay in the Hospital, in Post–Acute Care, and in the Combination of Hospital Plus Post–Acute Care



Estimates are adjusted for patient age, sex, race, and Elixhauser comorbidities. The median number of hospital discharges to home per year was 6 664 718 (interquartile range [IQR], 5 768 018-7 367 173) and the median number of discharges to post–acute care per year was 2 151 959 (IQR, 1 978 709-2 199 801).

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Author Contributions: Dr Werner had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
Concept and design: Both authors.
Acquisition, analysis, or interpretation of data: Werner.
Drafting of the manuscript: Werner.
Critical revision of the manuscript for important intellectual content: Both authors.
Statistical analysis: Both authors.
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COMMENT & RESPONSE

Diagnosis and Treatment of Hidradenitis Suppurativa

To the Editor Drs Saunte and Jemec performed an illustrative review focused on the advances in diagnosis and treatment of hidradenitis suppurativa (HS).[1] However, the advances in imaging of the disease were not discussed.

For example, regarding the pathogenesis, ultrasound studies have allowed visualization of the hidden connections between the tunnels or fistulous tracts and fluid collections and the dilated and ruptured base of the hair follicles, which were illustrated in Figure 3 in the article.[1-3] Regarding the staging of hidradenitis, ultrasonography has also demonstrated that clinical evaluation and commonly used clinical scoring systems can miscategorize as healthy skin corporal segments with fluid collections or fistulous tracts underneath.[3] The latter findings on imaging can be critical because, as pointed out by the authors, the choice of therapy is guided by disease severity. Currently, color Doppler ultrasound can support the detection of key subclinical lesions, the staging of the disease, and the assessment of activity and has been added to the clinical evaluation of hidradenitis in many centers around the world.[3,4] Moreover, ultrasound is also being used in ongoing trials.

In patients with indications for local or systemic treatments, imaging can be a noninvasive tool for monitoring the response. In patients with a surgical indication, an image-guided mapping of the extent of the abnormalities can be performed. Ultrasound has the ability to detect, categorize, and measure the lesions in all the corporal regions affected by hidradenitis.[3] This imaging information may allow better selection of the type of medical treatment or the location and extent of the surgical incision.[3]

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CLINICAL INVESTIGATION

Successful Discharge to Community Gap of FFS Medicare Beneficiaries With and Without ADRD Narrowed

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BACKGROUND/OBJECTIVES: We sought to compare the post-acute and long-term care experience of Medicare beneficiaries with and without Alzheimer Disease and Related Dementias (ADRD), and whether differences changed from January 1, 2007 to September 30, 2015.

DESIGN: Retrospective cross-sectional trend study using Medicare claims linked to the Centers for Medicare & Medicaid Services' (CMS) Minimum Data Set.

SETTING: CMS-certified skilled nursing facilities (skilled nursing facility (SNF), n = 17,043).

PARTICIPANTS: Fee-for-service Medicare beneficiaries aged ≥66 years (n = 6,614,939) discharged from a hospital to a SNF who had not lived in a nursing home during the year before hospitalization.

MEASUREMENTS: ADRD was defined by the Chronic Condition Data Warehouse. Outcome measures included: (1) successful discharge defined as being in SNF less than 90 days, then discharged back to the community, alive without subsequent inpatient health care for 30 continuous days; (2) became long-stay resident in SNF; (3) death in SNF within 90 days; (4) hospital readmission within 30 days of entering SNF; and (5) transferred to another nursing home within 30 days of entering SNF.

RESULTS: Successful discharge of beneficiaries with ADRD increased from 43.4% in 2007 to 53.9% in 2015 (average annual percent change (AAPC) = 2.1 (95% CI = 2.0–2.2)); those without ADRD also increased (from 59.1% to 63.6%, AAPC = 0.9 (95% CI = 0.7–1.1)) but not as fast as those with ADRD ($P < .01$). The proportion of all beneficiaries who became long-stay or were readmitted to the hospital decreased ($P < .05$). The proportion with ADRD who became long-stay was nearly three times higher than those without throughout the study (15.0% vs 5.5% in 2007; 11.3% vs 4.3% in 2015).

CONCLUSION: Though disparity in ADRD in becoming long-stay residents remains, the increase in successful discharges among those with ADRD also stresses the increasing importance of community as a care setting for adults with ADRD. **J Am Geriatr Soc 00:1-7, 2020.**

Keywords: ADRD; successful discharge; disparity

INTRODUCTION

Between 2010 and 2016 20.3% of Medicare beneficiaries received post-acute care (PAC) services in a skilled nursing facility (SNF) after being discharged from the hospital.[1] The improving Medicare Post-Acute-Care Transformation Act of 2014 mandated addition of a national quality measure for successful community discharge from PAC services. Although the goal of PAC rehabilitation is to maximize independence and facilitate a safe community transition, some SNF patients may be awaiting family arrangements to provide care at home or for selection of a long-term nursing facility. Some may need to stabilize and to get their numerous medical conditions to a manageable care plan. But generally, returning to and remaining in the community after an illness, injury, or surgery reflects the quality of PAC[2] (https://impactcollaboratory.org/). Although some studies have assessed inpatient rehabilitation facilities patients' success in

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community discharge,[3,4] little is known about SNF patients' success in returning and staying home post-discharge.

SNF admission is often the gateway to becoming a long-term nursing home resident. And, Alzheimer Disease and Related Dementias (ADRD) patients are more likely to become long-stay residents. The Affordable Care Act (ACA) and other policy initiatives strongly encourage community based long-term care for ADRD patients.[5] In 2012, under the ACA the Centers for Medicare & Medicaid Services (CMS) could penalize hospitals for readmissions in less than 30 days for certain conditions. Successful transitioning from the hospital to a SNF is even more complicated for persons with ADRD. For example, patients with ADRD whose behavioral problems surpass the SNF's capacity to accommodate them are at high risk of rehospitalization or transfer to a different SNF.[6] For this reason, SNF administrators may be less likely to accept patients with ADRD after acute hospitalization. Indeed, one study reported that SNF personnel believe hospital personnel downplay ADRD patients' behavioral problems to increase their chances of SNF admission.[6] For these reasons, real and perceived about patients with ADRD, we hypothesized that Medicare beneficiaries with ADRD would experience more negative outcomes than those without ADRD, in terms of their likelihood of successfully returning home, experiencing rehospitalization, dying in the SNF, becoming a permanent nursing home resident, or transferring to another SNF, and we assessed whether the differences changed between 2007 and 2015.

METHODS

Study Population

Our sample was drawn from 100% of Medicare SNF claims linked to the CMS Minimum Data Set, which are mandatory clinical assessments for all nursing home residents of Medicare-certified nursing homes, from January 1, 2007 through September 30, 2015 (with follow-up for post-discharge outcomes dated through December 31, 2015). The study period was chosen to include only events occurring before the introduction of the ICD-10 coding system. We included fee-for-service Medicare beneficiaries aged ≥66 years who were discharged alive from the hospital and admitted to a SNF within 1 day of hospital discharge. We excluded those with history of being in a nursing home within the 12 months (using the MDS) before hospital admission because they were likely to be sicker and/or more severely demented.[7]

Main Exposure Measure

We identified Medicare beneficiaries with ADRD using the Chronic Condition Data Warehouse (CCW) flag in the Medicare beneficiary summary file as of the day of hospital discharge. The CCW algorithm identifies beneficiaries as having ADRD if they have one of 24 ICD-9 codes present on one or more inpatient, SNF, HHA, outpatient, or carrier claim over a 3-year look-back period.[8] This definition has a sensitivity (0.85) and specificity (0.89).[9] We believe this is sufficient to assess changes in trends because (1) the measure did not change during the study period (ICD-9 codes were used throughout) and (2) we hypothesized post-discharge outcomes of ADRD patients may differ from those without ADRD, in part due to perceptions of ADRD patients. In other words, regardless of truly having ADRD, if beneficiaries' have an ADRD diagnosis, then healthcare providers perceive that they have ADRD.

Outcome Measures

We assessed trends over our study period in seven outcome measures. First, we defined successful discharge as being discharged alive from a SNF to the community within 90 days of SNF admission without subsequent inpatient healthcare utilization for 30 continuous days. Second, we defined becoming a long-stay resident as remaining in the SNF more than 90 days after SNF admission. Third, we defined dying in the SNF as dying within 90 days of SNF admission. Fourth, we assessed death within 90 days after discharge from the SNF (after being in the SNF at least 90 days). We assessed rehospitalization two ways: within 30 days and within 90 of hospital discharge. For both rehospitalization measures, those who died in the same

Table 1. Characteristics of Medicare Beneficiaries Aged 66 years and Older with Hospital Discharge to Nursing Home

	January 1 to December 31, 2007		January 1 to December 31, 2011		January 1 to September 30, 2015	
	ADRD N = 211,518	No ADRD N = 406,667	ADRD N = 277,751	No ADRD N = 484,728	ADRD N = 217,990	No ADRD N = 370,702
Age, mean	84.1	80.5	84.5	80.3	84.6	80.0
Female (%)	67.0	67.7	66.5	66.9	64.9	64.9
Black (%)	8.0	6.2	8.4	6.6	8.6	6.9
Other race (%)	3.4	3.1	4.1	3.5	4.6	3.9
Dual eligible (%)	18.0	11.4	18.1	11.0	16.9	10.3
# of hospitalized days, mean	8.1	8.6	7.6	7.8	7.4	7.7
Residential ZIP code Medicare Advantage penetration, mean %	17.8	17.6	22.7	22.4	28.7	28.1
Residential ZIP code dual-eligible rate, mean %	13.0	12.5	13.1	12.5	12.7	12.2

Table 2. FFS Medicare Beneficiaries Aged >65 Years Discharged from Hospital to SNF by Year, January 1, 2007 Through September 30, 2015

Discharge: Categories	AAPC (95% CI)	2007 N = 211,518	2008 N = 271,953	2009 N = 265,601	2010 N = 279,013	2011 N = 277,751	2012 N = 282,761	2013 N = 283,171	2014 N = 288,361	2015 N = 217,990
With Alzheimer's disease and other related dementias										
Successful discharge SNF to community	2.0 (1.8,2.2)	43.5%	44.1%	45.7%	46.5%	47.4%	48.3%	49.3%	50.1%	50.9%
Long-stay	−3.6 (−4.4, −2.8)	15.0%	14.2%	13.4%	12.5%	12.2%	11.8%	11.7%	11.3%	11.3%
Death in SNF	−0.7 (−1.1, −0.3)	16.9%	17.0%	16.2%	16.3%	16.1%	16.4%	16.2%	16.1%	15.8%
Death within 90 days of discharge from SNF	−0.2 (−1.0, 0.7)	8.9%	8.3%	8.2%	8.4%	8.4%	8.6%	8.4%	8.6%	8.2%
Re-entered hospital within 30 days	−2.8 (−3.6, −2.0)	16.0%	16.4%	16.1%	15.8%	15.3%	14.5%	13.8%	13.5%	13.4%
Re-entered hospital within 90 days	−1.7 (−2.3, −1.2)	27.4%	27.8%	27.4%	27.3%	26.6%	25.9%	24.8%	24.8%	24.6%
Patient was transferred from SNF to another facility within 30 days	−2.0 (−3.3, −0.7)	5.0%	4.7%	4.5%	4.2%	4.2%	4.1%	4.1%	4.3%	4.3%
		N = 406,667	N = 507,801	N = 497,452	N = 510,887	N = 484,728	N = 480,412	N = 488,342	N = 489,829	N = 370,702
Without Alzheimer's disease and other related dementias										
Successful discharge SNF to community	1.0 (0.8,1.2)	59.0%	58.6%	59.5%	60.1%	61.1%	61.8%	62.5%	62.7%	62.9%
Long-stay	−3.4 (−4.3, −2.6)	5.5%	5.3%	5.0%	4.8%	4.6%	4.4%	4.4%	4.3%	4.3%
Death in SNF	−1.4 (−1.8, −0.9)	13.9%	14.0%	13.5%	13.2%	12.9%	12.9%	12.8%	12.8%	12.8%
Death within 90 days of discharge from SNF	−1.1 (−1.5, −0.6)	6.3%	6.2%	6.1%	6.0%	5.9%	5.9%	5.7%	5.9%	5.7%
Re-entered hospital within 30 days	−2.9 (−3.6, −2.1)	16.5%	16.8%	16.4%	16.1%	15.5%	14.7%	14.0%	13.8%	13.9%
Re-entered hospital within 90 days	−2.1 (−2.7, −1.5)	26.8%	27.2%	26.7%	26.3%	25.5%	24.6%	23.6%	23.5%	23.6%
Patient was transferred from SNF to another facility within 30 days	−3.1 (−4.4, −1.8)	3.5%	3.3%	3.1%	2.9%	2.8%	2.7%	2.7%	2.7%	2.8%

Note: All years are from January 1 to December 31, except 2015 is from January 1 to September 30. Adjusted for age, sex, race, dual eligible status, % MA penetration in zipcode, % dual eligible in zipcode. AAPC, average annual percentage change; CI, confidence interval; died in SNF, within 30 days of entering SNF; FFS, fee-for-service; long-stay, still in SNF after 90 days of entering; SNF, skilled nursing facility; successful discharge, in SNF 90 days, then they were discharged back to the community, alive without subsequent inpatient healthcare utilization for 30 continuous days.

timeframe were censored. Finally, we assessed transfer to another NH within 30 days of entering the SNF. To clarify "SNF," our focus is not on SNF coverage for payment, but rather PAC in a SNF which is typically short-stay or ≤90 days. We used the sequence of claims and the MDS to identify outcomes.

Statistical Analyses

First, we assessed the overall change in number of beneficiaries with and without ADRD from 2007 to 2014 (for this we excluded 2015 because it was a partial year). Trends for each outcome were then assessed on annual cohorts of beneficiaries who were discharged from the hospital to a SNF, adjusting for age, sex, race, dual-eligibility, Medicare Advantage penetration (zipcode of residence), and percent dual-eligible (zipcode of residence). We used STATA version 16 software to obtain adjusted predictive margins and standard errors. We evaluated monotonic trends by joinpoint regression using Joinpoint software,[10] which has the same underlying assumptions as simple regression and allows for input of estimates and standard errors. To determine if the trend was statistically significant we used the average annual percent change (AAPC) and its associated *P*-value. We also compared AAPC differences in trends between those with and without ADRD. All analyses were stratified by beneficiary ADRD status.

Sensitivity Analyses

Because our analyses included all FFS beneficiaries discharged from the hospital to a SNF, we wanted to determine if results would be similar for a more homogenous group or if our findings were driven by certain subgroups. Therefore, we performed the same trend analyses for patients hospitalized for hip fractures and were discharged from the hospital to a SNF. Codes used to define hip fractures were 820.xx.

All analyses were conducted after establishing a data use agreement with CMS and obtaining final approval from Brown University's Institutional Review Board.

RESULTS

We identified 2,134,798 beneficiaries with prevalent ADRD (243,321 or 11.4% were included in multiple years) and 3,582,546 without (654,274 or 18.3% were included in multiple years) who otherwise met study eligibility criteria. The average age of beneficiaries with ADRD discharged from hospital to SNF was close to 84 years in 2007, 2011, and 2015; the average age of those without ADRD was approximately 80 years at the beginning, middle, and end of the study (Table 1). About two-thirds of those with and without ADRD were female. The average proportion with Medicare Advantage penetration in the residents' zip code increased from 2007 to 2015 for those with (17.8%–28.7%) and without ADRD (17.6%–28.1%). A few (7.4% n = 486,715) of beneficiaries were referred to a hospice within 90 days of entering the SNF or in the 90 days following SNF discharge; of those, 85.2% died.

The number of beneficiaries with ADRD discharged from the hospital to a SNF increased 36.3% from 211,518 in 2007 to 288,361 in 2014 (2015 was a partial year, AAPC = 3.1 (0.3, 5.9)). There was no significant change in the number of beneficiaries without ADRD discharged from the hospital to a SNF from 2007 to 2014 (AAPC = 1.1 (−1.6, 3.9)). The proportion of traditional Medicare beneficiaries with ADRD who had a successful discharge from the SNF to the community increased from 43.5% in 2007 to 50.9% in 2015 (AAPC = 2.0 (1.8, 2.2)) (Table 2 and Figure 1). Successful discharge for those without ADRD also increased (from 59.0% to 62.9%, AAPC = 1.0 (0.8, 1.2)), but not as fast as for those with ADRD (AAPC difference (ADRD − No ADRD) = 1.0 (0.8, 1.2), $P < .01$). The proportion of beneficiaries with ADRD who became long-stay nursing home residents decreased (from 15.0% in 2007 to 11.3% in 2015, AAPC = −3.6 (−4.4, −2.8)); those without ADRD decreased also (from 5.5% to 4.3%, AAPC = −3.4 (−4.3, −2.6)) similar to those with ADRD ($P = .70$). However, the proportion of those with ADRD who became long-stay was nearly three times higher than those without. The proportion of beneficiaries with ADRD who died within 90 days of entering the SNF decreased from 2007 (16.9%) to 2015 (15.8%, AAPC = −0.7 (−1.2, −0.2)); those without ADRD decreased as well from 13.9% in 2007 to 12.8% in 2015 (AAPC = −1.4 (−1.8, −0.9)), faster than those with ADRD (AAPC difference (ADRD − No ADRD) = 0.9 (1.7, 0.1), $P < .01$). The proportion of beneficiaries with ADRD who died within 90 days of discharge from the SNF did not change from 2007 (8.9%) to 2015 (8.2%, $P = .7$); those without ADRD decreased from 6.3% in 2007 to 5.7% in 2015 (AAPC = −1.1 (−1.5, −0.6)), faster than those with ADRD (AAPC difference (ADRD − No ADRD) = 0.9 (1.7, 0.1), $P < .01$). The

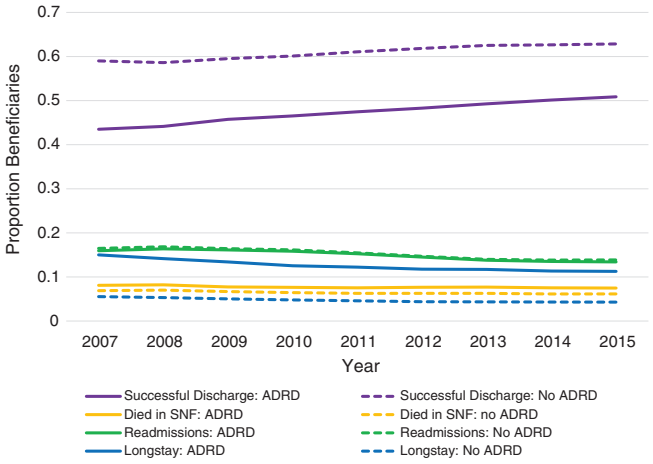

Figure 1. Adjusted proportion of FFS Medicare Beneficiaries aged >65 years discharged from hospital to SNF by ADRD status, January 1, 2007 through September 30, 2015. Adjusted for age, sex, race, dual eligible status, % MA penetration in zipcode, % dual eligible in zipcode. ADRD, Alzheimer's disease and related dementias; died in SNF, within 30 days of entering SNF; FFS, fee-for-service; long-stay, still in SNF after 90 days of entering; readmissions, readmitted to hospital within 30 days of entering SNF; SNF, skilled nursing facility; successful discharge, in SNF 90 days, then they were discharged back to the community, alive without subsequent inpatient healthcare utilization for 30 continuous days.

Table 3. FFS Medicare Beneficiaries Aged >65 Years Hospitalized for Hip Fractures and Discharged to SNF by Year, January 1, 2007 Through September 30, 2015

Discharge: Categories	AAPC (95% CI)	2007 N = 23,485	2008 N = 29,321	2009 N = 29,445	2010 N = 30,215	2011 N = 29,772	2012 N = 30,408	2013 N = 31,483	2014 N = 31,882	2015 N = 23,500
With Alzheimer's disease and other related dementias										
Successful discharge SNF to community	2.1 (1.8,2.4)	43.2%	44.0%	45.6%	46.1%	47.4%	47.6%	49.5%	50.6%	50.6%
Long-stay	−3.0 (−3.9, −2.1)	16.0%	14.7%	14.3%	13.5%	13.3%	12.9%	13.0%	12.3%	12.4%
Death in SNF	−1.4 (−2.2, −0.5)	16.1%	16.5%	14.8%	15.1%	14.9%	15.0%	14.7%	14.6%	14.5%
Death within 90 days of discharge from SNF	−0.2 (−1.2, 0.7)	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
Re-entered hospital within 30 days	−3.4 (−4.6, −2.3)	14.9%	15.6%	14.7%	14.9%	13.6%	13.2%	12.2%	12.0%	12.4%
Re-entered Hospital within 90 days	−2.3 (−3.3, −2.0)	23.8%	25.0%	24.2%	24.2%	22.8%	22.3%	20.9%	20.8%	21.6%
Patient was transferred from SNF to another facility within 30 days	−2.0 (−3.7, −0.3)	6.8%	6.1%	5.9%	5.5%	5.4%	5.5%	5.4%	5.7%	5.6%
		N = 36,725	N = 44,544	N = 43,394	N = 44,026	N = 41,341	N = 40,683	N = 41,740	N = 42,804	N = 31,612
Without Alzheimer's disease and other related dementias										
Successful discharge SNF to community	1.2 (1.1,1.4)	62.6%	62.9%	63.9%	63.9%	65.4%	65.8%	67.2%	67.7%	68.6%
Long-stay	−3.8 (−4.5, −3.0)	6.3%	5.8%	5.6%	5.4%	5.2%	5.0%	4.5%	4.7%	4.7%
Death in SNF	−2.9 (−3.7, −2.2)	9.2%	9.1%	8.8%	8.6%	7.8%	7.8%	7.7%	7.7%	7.3%
Death within 90 days of discharge from SNF	−1.5 (−2.7, −0.3)	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%
Re-entered hospital within 30 days	−3.2 (−4.1, −2.4)	13.1%	13.4%	12.9%	12.9%	12.2%	11.9%	11.1%	10.6%	10.5%
Re-entered hospital within 90 days	−2.7 (−3.3, −2.0)	21.9%	21.8%	21.3%	21.4%	20.5%	19.9%	18.5%	18.4%	18.2%
Patient was transferred from SNF to another facility within 30 days	−4.2 (−5.4, −3.0)	5.1%	4.8%	4.5%	4.1%	3.9%	3.9%	3.7%	3.7%	3.8%

Note: All years are from January 1 to December 31, except 2015 is from January 1 to September 30. Adjusted for age, sex, race, dual eligible status, % MA penetration in zipcode, % dual eligible in zipcode. AAPC, average annual percentage change; CI, confidence interval; died in SNF, within 30 days of entering SNF; FFS, fee-for-service; long-stay, still in SNF after 90 days of entering; SNF, skilled nursing facility; successful discharge, in SNF 90 days, then they were discharged back to the community, alive without subsequent inpatient healthcare utilization for 30 continuous days.

proportion of beneficiaries discharged and rehospitalized within 30 days and 90 days decreased among both those with (AAPC = −2.8 (−3.6, −2.0) and AAPC = −1.7 (−2.3, −1.2)) and without ADRD (APC = −2.9 (−3.6, −2.1) and AAPC = −2.1 (−2.7, −1.5)) during the study period, though not significantly different from each other (P = .90 and P = .20, respectively). The proportion of beneficiaries discharged to SNF and transferred to another nursing facility decreased among both those with ADRD from 5.0% to 4.3% (AAPC = −2.0 (−3.3, −0.7)) and without ADRD from 3.5% to 2.8% (AAPC = −3.1 (−4.4, −1.8)), though not significantly different from each other (P = .20).

Results of Sensitivity Analyses

Overall, 9.5% of patients discharged had claims for being hospitalized with hip fracture. The number of beneficiaries discharged from the hospital to a SNF increased 35.8% from 23,485 in 2007 to 31,882 in 2014 (2015 was a partial year and therefore excluded, AAPC = 3.1 (0.7, 5.6)). There was no significant change in beneficiaries without ADRD discharged from the hospital to a SNF (AAPC = 0.6 (−1.8, 3.1). Those hospitalized for hip fracture, with and without ADRD, experienced more successful SNF-to-community discharges after acute hospitalization, fewer deaths, rehospitalizations, long-stays, and transfers to other nursing facilities within 30 days of entering the SNF from 2007 to 2015 (P < .05) (Table 3). The gap between those with and without ADRD in successful SNF-to-community discharges after acute hospitalization narrowed, as rates of successful discharges increased faster among those with ADRD (AAPC difference (ADRD − No ADRD) = 0.9 (0.6, 1.2)).

DISCUSSION

In general, traditional Medicare beneficiaries with ADRD have worse outcomes than those without ADRD, but the gap is narrowing with respect to returning home from the SNF, surviving and not being rehospitalized. From 2007 to 2015, Medicare beneficiaries experienced more successful SNF-to-community discharges after acute hospitalization, due to fewer rehospitalizations, long-stays, and transfers to other nursing facilities within 30 days of entering the SNF. The gap between those with and without ADRD in successful SNF-to-community discharges after acute hospitalization narrowed, as the rates of successful discharges increased faster among those with ADRD. Deaths within 90 days of discharge to SNF did not change among beneficiaries with ADRD, yet the mortality rate decreased among the non-ADRD group. Notably, the gap between those with and without ADRD in becoming long-stay remained; those with ADRD were nearly three times as likely to become long-stay residents.

Studies have reported an increase in the number of adults living with ADRD.[11] This is reflected in our study showing an increase in ADRD patients discharged from the hospital to the SNF overall and also in our sensitivity analysis among hospitalizations for hip fractures. Our results may indicate that the greater number of patients with ADRD discharged home may reflect healthier people being diagnosed with ADRD at earlier stages.

Higher rates of successful discharge from SNF to the community and fewer rehospitalizations, long-stays, and transfers to other nursing facilities among beneficiaries with ADRD over a decade are quite encouraging. Previous studies have reported persons with ADRD experience frequent transitions across the range of care, especially into and out of hospital and SNF settings.[12,13] And, nearly half of long-stay nursing home residents suffer from ADRD.[14,15] Our data suggest that the proportion of patients with ADRD who become long-stay residents after entering the SNF after being hospitalized is decreasing.

It is not surprising that rates of rehospitalization after hospital discharge to SNF decreased for all beneficiaries. In October 2012 a policy was mandated by the ACA to penalize hospitals with high readmission rates for certain conditions.[16] Readmission rates for some SNFs may have been high before 2012 because of the change in use of SNF care. Most SNFs (>90%) are dually certified as a SNF and as a nursing home.[17] Thus, a facility that offers skilled care often also provides long-term care services that Medicare does not cover. Ideally, SNF care is provided to restore function to patients discharged from acute hospital care before transitioning back to the community. In the decade before 2012, use of SNF care after acute hospitalization had greatly increased in part because of the shift of nursing homes from serving life long residents to facilities treating increasingly medically complex patients seeking PAC for recuperation after hospitalization. This may in part have been driven by a financial incentive to take advantage of the short-term Medicare benefit. Medicare covers up to 100 days after 3 days of hospitalization whereas Medicaid pays for most of long-term care, the Medicare payment for SNF services being higher than that for Medicaid. In other words, some patients may have been sent to the SNF as long as the financial benefit was available and then sent back to the hospital. Yet since the 2012 policy, that practice likely diminished.

Our result of decline in long-stay residents, with and without ADRD, helps to explain why occupancy in nursing homes continues to decline even though the number of beds has been steadily declining.[18-20] In nursing homes in states with no or nursing home-specific certificate-of-need programs (designed to curb healthcare spending), the number of beds has decreased since 1992.[21] The decline in long-stay residents may also be a reflection of the number of nursing home closures. Facilities with large proportions of long-stay residents tended to have high Medicaid occupancy,[22] and those facilities were most at risk of closure.[23]

Our study was subject to several limitations. First, discharge data for the Medicare Advantage population are not reliable and therefore were not included. Given the rapid growth of Medicare Advantage, which has a strong disincentive for hospital use, the results observed may not reflect the overall population aged 66 years and older. Second, the proportion of ADRD we reported likely includes some false-positive and false-negative ADRD cases; however, the CCW algorithm is the only approach that can identify a broad sample of beneficiaries with ADRD across community and nursing home settings in hospitalization data. Still, regardless of how ADRD is diagnosed, the trends reveal an increase in successful discharges but a steady gap in becoming long-stay residents with a nearly threefold risk among

those with ADRD. Third, we did not assess the geographic availability of PAC services; hence some patients may have been discharged to the community because of access rather than recovery. Fourth, we could not account for health beliefs, financial resources, availability of an appropriate caregiver (paid or unpaid), or cultural differences which may have influenced discharge to and remaining in the community. Finally, a potential limitation is that certain cohorts of beneficiaries discharged from the hospital to SNFs could have driven the results. However, sensitivity analyses confirmed overall results with a homogenous group. Among patients who had been hospitalized for hip fractures, trends for those with and without ADRD were in the same direction and the same estimates were statistically significant as were found for the overall group of beneficiaries with two exceptions.

We examined the trends in outcomes among Medicare beneficiaries discharged to SNF with and without a diagnosis of ADRD and found that many outcomes improved for all persons but that successful discharge rates, going home and remaining there, improved more rapidly for persons living with dementia than for persons without dementia. It may be that practices with regard to hospitalization may have influenced the trends in addition to practices in the SNF. Thus, more research is needed to understand what is driving the reduction in transfers, deaths, and long-stays among patients with ADRD discharged from hospital to SNF. In addition, the increase in successful SNF to community discharges stresses the increasing importance of community as the care setting for adults with ADRD.

ACKNOWLEDGMENTS

Conflict of Interest: BHB, MR, CK, and RMW have no conflicts of interest to report. VM receives compensation for his role as Chair of the Scientific Advisory Committee of naviHealth, a post-acute care convening company serving managed care companies and integrated hospital systems.

Author Contributions: VM and MR conceived and designed the study. BHB drafted the manuscript and did the statistical analyses. MR and CK obtained and compiled the data. All authors revised the report for intellectual content and contributed to the literature search. VM and RMW provided administrative, technical and material support.

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Tab 13 NF RUC Summary

Updated: 6/21/20224:48 PM

ISSUE: Nursing Facility Discharge Day Services

TAB: 12

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99495	XXX	Transitional Care Management Services with the following	2018-10	78	0.051	0.051			2.78			54						54								
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	33	0.041	0.041			1.92			47	7					30			10					
CURRENT	99315	XXX	Nursing facility discharge day management; 30 minutes or less	2010-10		0.042	0.032			1.28			40	10					20			10					
SVY	99315	XXX	Nursing facility discharge day management; 30 minutes or less		185	0.071	0.053	0.50	1.50	2.10	2.78	8.00	40	10			0	20	25	30	125	5	0	0	10	28	450
REC	99315	XXX	Nursing facility discharge day management; 30 minutes or less			0.047	0.038			1.50			40	10					25			5					
1st REF	99496	XXX	Transitional Care Management Services with the following	2018-10	88	0.051	0.051			3.79			75						75								
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.040	0.040			2.80			70	10					45			15					
CURRENT	99316	XXX	Nursing facility discharge day management; more than 30 minutes	2010-10		0.050	0.035			1.90			54	14					25			15					
SVY	99316	XXX	Nursing facility discharge day management; more than 30		191	0.062	0.048	0.75	2.50	3.01	3.80	9.00	63	15			0	30	40	50	120	8	0	0	10	40	800
REC	99316	XXX	Nursing facility discharge day management; more than 30 minutes			0.050	0.040			2.50			63	15					40			8					
DELETED	99318	XXX	Evaluation and management of a patient involving an annual nursing	2007-02		0.047	0.036			1.71			47	10					27			10					

FACILITY DIRECT PE INPUTS **CPT CODE(S):99315, 99316**

SPECIALTY SOCIETY(IES):_AAPM&R, ACP, AGS, AMDA, ANA, APMA

PRESENTER(S): Charles Crecelius, MD, PhD, CMD; Audrey Chun, MD; MD; Charles Hamori, MD; Carlo Milani, MD; and Korinne Van Keuren, DNP, APRN; Elizabeth Volpert, DNP, APRN

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
99315	Nursing facility discharge day management; 30 minutes or less	XXX
99316	Nursing facility discharge day management; more than 30 minutes	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99315	Final nursing facility day visit for a 72-year-old male with congestive heart failure and multiple comorbidities, who is being discharged home on diet and oral medications.
99316	Final nursing facility day visit for an 84-year-old male who suffered a cerebrovascular accident with hemiparesis and who has congestive heart failure, peripheral vascular disease and diabetes. The patient needs help transferring and is unable to administer his own insulin but has adequate supports at home to be discharged to the community.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The specialty society expert panel, comprised of advisors from the participating specialties, met and discussed recommendations for practice expense both via phone and over email. The expert panel reviewed the existing PE inputs for the code family and made revisions as necessary to reflect current practice.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing PE inputs from 2004 (99315 and 99316) were used as reference.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

Pre-Service
All codes include time for an activity described in 2004 and 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA005 Complete pre-procedure phone calls and prescription.

Post-Service
All codes include time for an activity described in 2004 and 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA037 Conduct patient communications.
Codes 99315 and 99316 included time for an activity described in the 2004 PE spreadsheet as "Coordinate home or outpatient care." This has been rolled into CA038 Coordinate post-procedure services.

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

99315	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit.
99316	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit.

   b. Service period (includes pre, intra and post):

   c. Post-service period:

99315	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 6 minutes** Staff confirms procedure/therapy/DME orders associated with patient discharge. Staff assists in coordination of care with primary care physician and relevant outpatient therapy and home health providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99316	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 6 minutes** Staff confirms procedure/therapy/DME orders associated with patient discharge. Staff assists in coordination of care with primary care physician and relevant outpatient therapy and home health providers.

		Staff assists in interfacing between documentation in facility EMR and physician EMR.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A

14. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

15. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

N/A

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?

c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

NONFACILITY DIRECT PE INPUTS **CPT CODE(S):99315 99316**

SPECIALTY SOCIETY(IES):_AAPM&R, ACP, AGS, AMDA, ANA, APMA_

PRESENTER(S): Charles Crecelius, MD, PhD, CMD; Audrey Chun, MD; Charles Hamori, MD; Carlo Milani, MD; Korinne Van Keuren, DNP, APRN and Elizabeth Volpert, DNP, APRN

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
99315	Nursing facility discharge day management; 30 minutes or less	XXX
99316	Nursing facility discharge day management; more than 30 minutes	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99315	Final nursing facility day visit for a 72-year-old male with congestive heart failure and multiple comorbidities, who is being discharged home on diet and oral medications.
99316	Final nursing facility day visit for an 84-year-old male who suffered a cerebrovascular accident with hemiparesis and who has congestive heart failure, peripheral vascular disease and diabetes. The patient needs help transferring and is unable to administer his own insulin but has adequate supports at home to be discharged to the community.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The specialty society expert panel, comprised of advisors from the participating specialties, met and discussed recommendations for practice expense both via phone and over email. The expert panel reviewed the existing PE inputs for the code family and made revisions as necessary to reflect current practice.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing PE inputs from 2004 (99315 and 99316) were used as reference.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Non-Facility Dominant Specialties

99315	Non-Facility Dominant Specialties – internal medicine (36.9%), nurse practitioner (30.5%), family medicine (20.7%)
99316	Non-Facility Dominant Specialties – nurse practitioner (43.5%), internal medicine (29.4%), family medicine (12.9%)

There are small differences in the percentages and order of the dominant specialties when comparing non-facility to global dominant specialties.

Global Dominant Specialties

99315	Non-Facility Dominant Specialties – nurse practitioner (35.6%), internal medicine (30.5%), family medicine (19.4%)
99316	Non-Facility Dominant Specialties – nurse practitioner (49.6%), internal medicine (24.8%), family medicine (10.2%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

Pre-Service
All codes include time for an activity described in 2004 and 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA005 Complete pre-procedure phone calls and prescription.

Post-Service
All codes include time for an activity described in 2004 and 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA037 Conduct patient communications.
Codes 99315 and 99316 included time for an activity described in the 2004 PE spreadsheet as "Coordinate home or outpatient care." This has been rolled into CA038 Coordinate post-procedure services.

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

99315	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit.
99316	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit.

   b. Service period (includes pre, intra and post):

   c. Post-service period:

99315	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 6 minutes** Staff confirms procedure/therapy/DME orders associated with patient discharge. Staff assists in coordination of care with primary care physician and relevant outpatient therapy and home health providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99316	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 6 minutes** Staff confirms procedure/therapy/DME orders associated with patient discharge. Staff assists in coordination of care with primary care physician and relevant outpatient therapy and home health providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

N/A

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):
    N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
    N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
    N/A

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
    N/A

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:
    N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:
    N/A

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:
    N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:
    N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

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NONFACILITY DIRECT PE INPUTS **CPT CODE(S):99315 99316**

SPECIALTY SOCIETY(IES):_AAPM&R, ACP, AGS, AMDA, ANA, APMA_

PRESENTER(S): Charles Crecelius, MD, PhD, CMD; Audrey Chun, MD; Charles Hamori, MD; Carlo Milani, MD; Korinne Van Keuren, DNP, APRN and Elizabeth Volpert, DNP, APRN

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

	A	B	D	E	F	AK	AL	AM	AN	AO
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CUR**
2						**CPT Code 99315**		**CPT Code 99315**		**CPT Co**
3		***RUC Collaboration Website***				Nursing facility discharge day management; 30 minutes or less		Nursing facility discharge day management; 30 minutes or less		Nursing discha managem than 30
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 4.44**	**$ 4.44**	**$ 4.44**	**$ 4.44**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ 4.44**	**$ 4.44**	**$ 4.44**	**$ 4.44**	**$ 4.44**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001	Complete pre-service diagnostic and referral forms	L037D	RN/LPN/MTA	0.37					
16	CA002	Coordinate pre-surgery services (including test results)	L037D	RN/LPN/MTA	0.37					
17	CA003	Schedule space and equipment in facility	L037D	RN/LPN/MTA	0.37					
18	CA004	Provide pre-service education/obtain consent	L037D	RN/LPN/MTA	0.37					
19	CA005	Complete pre-procedure phone calls and prescription	L037D	RN/LPN/MTA	0.37	3	3	3	3	3
20	CA006	Confirm availability of prior images/studies	L037D	RN/LPN/MTA	0.37					
21	CA007	Review patient clinical extant information and questionnaire	L037D	RN/LPN/MTA	0.37					
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)	L037D	RN/LPN/MTA	0.37					
23			L037D	RN/LPN/MTA	0.37					
26		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are [illegible]	L037D	RN/LPN/MTA	0.37					
34	CA010	Obtain vital signs	L037D	RN/LPN/MTA	0.37					
35	CA011	Provide education/obtain consent	L037D	RN/LPN/MTA	0.37					
36	CA012	Review requisition, assess for special needs	L037D	RN/LPN/MTA	0.37					
37	CA013	Prepare room, equipment and supplies	L037D	RN/LPN/MTA	0.37					
38	CA014	Confirm order, protocol exam	L037D	RN/LPN/MTA	0.37					
39	CA015	Setup scope (nonfacility setting only)	L037D	RN/LPN/MTA	0.37					
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient	L037D	RN/LPN/MTA	0.37					
41	CA017	Sedate/apply anesthesia	L037D	RN/LPN/MTA	0.37					
42			L037D	RN/LPN/MTA	0.37					
45		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
48		**Intra-service (of service period)**								
49	CA018	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37					
50	CA019	Assist physician or other qualified healthcare professional---directly	L037D	RN/LPN/MTA	0.37					
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other %)	L037D	RN/LPN/MTA	0.37					
52	CA021	Perform procedure/service---NOT directly related to physician work time	L037D	RN/LPN/MTA	0.37					
55			L037D	RN/LPN/MTA	0.37					
56		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
59		**Post-Service (of service period)**								
60	CA022	Monitor patient following procedure/service, multitasking 1:4	L037D	RN/LPN/MTA	0.37					
61	CA023	Monitor patient following procedure/service, no multitasking	L037D	RN/LPN/MTA	0.37					
62	CA024	Clean room/equipment by clinical staff	L037D	RN/LPN/MTA	0.37					
63	CA025	Clean scope	L037D	RN/LPN/MTA	0.37					
64	CA026	Clean surgical instrument package	L037D	RN/LPN/MTA	0.37					
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions	L037D	RN/LPN/MTA	0.37					
66	CA028	Review/read post-procedure x-ray, lab and pathology reports	L037D	RN/LPN/MTA	0.37					
67	CA029	Check dressings, catheters, wounds	L037D	RN/LPN/MTA	0.37					
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and decon cons	L037D	RN/LPN/MTA	0.37					
69	CA031	Review examination with interpreting MD/DO	L037D	RN/LPN/MTA	0.37					
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue	L037D	RN/LPN/MTA	0.37					
71	CA033	Perform regulatory mandated quality assurance activity (service period)	L037D	RN/LPN/MTA	0.37					
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, ECG file, etc.)	L037D	RN/LPN/MTA	0.37					
73	CA035	Review home care instructions, coordinate visits/prescriptions	L037D	RN/LPN/MTA	0.37					
74	CA036	Discharge day management	L037D	RN/LPN/MTA	0.37	**n/a**		**n/a**		**n/a**
75			L037D	RN/LPN/MTA	0.37					
78		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
81		**End: Patient leaves office/facility**								
82		**POST-SERVICE PERIOD**								
83		**Start: Patient leaves office/facility**								
84	CA037	Conduct patient communications	L037D	RN/LPN/MTA	0.37	3	3	3	3	3
85	CA038	Coordinate post-procedure services	L037D	RN/LPN/MTA	0.37	6	6	6	6	6
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16							
88		99212 27 minutes	27							
89		99213 36 minutes	36							
90		99214 53 minutes	53							
91		99215 63 minutes	63							
92	CA039	Post-operative visits (total time)	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93			L037D	RN/LPN/MTA	0.37					
96		*Other activity: please include short clinical description here and type new in column A*	L037D	RN/LPN/MTA	0.37					
99		**End: with last office visit before end of global period**								

	A	B	D	E	F	AK	AL	AM	AN	AO
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CUR**
2						**CPT Code 99315**		**CPT Code 99315**		**CPT Co**
3		***RUC Collaboration Website***				Nursing facility discharge day management; 30 minutes or less		Nursing facility discharge day management; 30 minutes or less		Nursing discha managem than 30
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021 Revision Date (if applicable): Tab: 13 Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**					
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ 4.44**	**$ 4.44**	**$ 4.44**	**$ 4.44**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D	RN/LPN/MTA	0.37	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102										
103										
104										
105										
106										
107										
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*								
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112										
113										
114										
115										
116										
117										
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*								

	A	B	AP	AQ	AR
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**	
2			**de 99316**	**CPT Code 99316**	
3		***RUC Collaboration Website***	facility	Nursing facility	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**	ge day ent; more minutes	discharge day mangement; more than 30 minutes	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 4.44**	**$ 4.44**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	**12.0**	**12.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**9.0**	**9.0**	**9.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ 4.44**	**$ 4.44**	**$ 4.44**
13		**PRE-SERVICE PERIOD**			
14		**Start: Following visit when decision for surgery/procedure made**			
15	CA001	Complete pre-service diagnostic and referral forms			
16	CA002	Coordinate pre-surgery services (including test results)			
17	CA003	Schedule space and equipment in facility			
18	CA004	Provide pre-service education/obtain consent			
19	CA005	Complete pre-procedure phone calls and prescription	3	3	3
20	CA006	Confirm availability of prior images/studies			
21	CA007	Review patient clinical extant information and questionnaire			
22	CA008	Perform regulatory mandated quality assurance activity (pre-service)			
23					
26		*Other activity: please include short clinical description here and type new in column A*			
29		**End: When patient enters office/facility for surgery/procedure**			
30		**SERVICE PERIOD**			
31		**Start: When patient enters office/facility for surgery/procedure:**			
32		**Pre-Service (of service period)**			
33	CA009	Greet patient, provide gowning, ensure appropriate medical records are [illegible]			
34	CA010	Obtain vital signs			
35	CA011	Provide education/obtain consent			
36	CA012	Review requisition, assess for special needs			
37	CA013	Prepare room, equipment and supplies			
38	CA014	Confirm order, protocol exam			
39	CA015	Setup scope (nonfacility setting only)			
40	CA016	Prepare, set-up and start IV, initial positioning and monitoring of patient			
41	CA017	Sedate/apply anesthesia			
42					
45		*Other activity: please include short clinical description here and type new in column A*			
48		**Intra-service (of service period)**			
49	CA018	Assist physician or other qualified healthcare professional---directly			
50	CA019	Assist physician or other qualified healthcare professional---directly			
51	CA020	Assist physician or other qualified healthcare professional---directly related to physician work time (other %)			
52	CA021	Perform procedure/service---NOT directly related to physician work time			
55					
56		*Other activity: please include short clinical description here and type new in column A*			
59		**Post-Service (of service period)**			
60	CA022	Monitor patient following procedure/service, multitasking 1:4			
61	CA023	Monitor patient following procedure/service, no multitasking			
62	CA024	Clean room/equipment by clinical staff			
63	CA025	Clean scope			
64	CA026	Clean surgical instrument package			
65	CA027	Complete post-procedure diagnostic forms, lab and x-ray requisitions			
66	CA028	Review/read post-procedure x-ray, lab and pathology reports			
67	CA029	Check dressings, catheters, wounds			
68	CA030	Technologist QC's images in PACS, checking for all images, reformats, and dose page			
69	CA031	Review examination with interpreting MD/DO			
70	CA032	Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue			
71	CA033	Perform regulatory mandated quality assurance activity (service period)			
72	CA034	Document procedure (non PACS) (e.g. mandated reporting, registry logs, EEG file, etc.)			
73	CA035	Review home care instructions, coordinate visits/prescriptions			
74	CA036	Discharge day management		n/a	
75					
78		*Other activity: please include short clinical description here and type new in column A*			
81		**End: Patient leaves office/facility**			
82		**POST-SERVICE PERIOD**			
83		**Start: Patient leaves office/facility**			
84	CA037	Conduct patient communications	3	3	3
85	CA038	Coordinate post-procedure services	6	6	6
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**
87		99211 16 minutes			
88		99212 27 minutes			
89		99213 36 minutes			
90		99214 53 minutes			
91		99215 63 minutes			
92	CA039	Post-operative visits (total time)	**0.0**	**0.0**	**0.0**
93					
96		*Other activity: please include short clinical description here and type new in column A*			
99		**End: with last office visit before end of global period**			

	A	B	AP	AQ	AR
1	**RUC Practice Expense Spreadsheet**		**RENT**	**RECOMMENDED**	
2			**de 99316**	**CPT Code 99316**	
3		***RUC Collaboration Website***	facility	Nursing facility	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**	ge day ent; more minutes	discharge day mangement; more than 30 minutes	
5		**LOCATION**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ 4.44**	**$ 4.44**	**$ 4.44**
8		**TOTAL CLINICAL STAFF TIME**	**12.0**	**12.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**9.0**	**9.0**	**9.0**
100	**Supply Code**	**MEDICAL SUPPLIES**			
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**
102					
103					
104					
105					
106					
107					
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*			
110	**Equipment Code**	**EQUIPMENT**			
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**
112					
113					
114					
115					
116					
117					
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*			

AMA/Specialty Society RVS Update Committee Summary of Recommendations

April 2021

Nursing Facility Services – Tab 13

Following the implementation of the revisions to the Evaluation and Management (E/M) office visits (99201-99215) for the CPT 2021 code set, the CPT/RUC Workgroup on E/M met twelve times in 2020 and early 2021 to standardize the rest of the E/M sections in the CPT code set. The CPT/RUC Workgroup on E/M was committed to changing the current coding and documentation requirements for E/M visits to simplify the work of the health care provider and improve the health of the patient. To achieve these goals, the Workgroup set forth the following guiding principles related to the group's ongoing work product:

1. To decrease administrative burden of documentation and coding and align CPT and CMS whenever possible
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties.

In February 2021, the CPT Editorial Panel deleted the annual nursing facility assessment code and revised seven nursing facility codes to align with the principles included in the E/M office visit services by documenting and selecting level of service based on total time or medical decision making.

Similar to the office visits, beginning in 2023, when total time on the date of encounter is used to select the appropriate level of a nursing facility visit service code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code. The nursing facility services were surveyed for the April 2021 RUC meeting. The survey time captured includes pre-service time 1-day before the date of encounter, intra-service time is all the time on the date of encounter and post-service time is 3-days after the date of encounter.

The RUC noted that all the of these services are typically performed in the skilled nursing facility which requires a higher level of care than the nursing facility.

COMPELLING EVIDENCE

In April 2021, the RUC met to review the nursing facility changes. The specialty societies indicated that there is compelling evidence based on flawed methodology. The specialty societies reviewed the methodology used by the RUC in 2007 to arrive at the current values. That methodology was inconsistent among the codes in the family and was not based on survey values or direct crosswalks. For example, 99304, the initial nursing visit code requiring low level medical decision making was valued based on the sum of the value of 99203, a new patient visit also requiring a low level of medical decision making, plus one-fourth the value of 99374, physician supervision of a patient under the care of a home health

agency. The RUC justified its recommendations for all the initial nursing visit codes by dividing the median time of the nursing visit code by the median time of the comparable subsequent hospital visit code, multiplying that fraction by the work RVU of the hospital visit code and adding one-fourth of 99374. Similarly, the methodology for valuing the subsequent nursing visit codes was inconsistent and differed from the methodology used for the initial visit codes. The RUC agreed that there is compelling evidence that the previous valuation was based on flawed methodology.

INITIAL NURSING FACILITY CARE

99304 ***Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.***
The RUC reviewed the survey results from 203 physicians and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the work required to perform this service. The RUC recommends 6 minutes of pre-service time, 25 minutes of intra-service time and 5 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60, 25 minutes intra-service time and 35 minutes total time) and determined that 99304 describing straightforward/low medical decision-making is appropriately slightly less physician work than CPT code 99203.

The RUC also compared 99304 to the second top key reference service 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93, 15 minutes intra-service time and 20 minutes total time) and determined that CPT code 99304 requires much more physician work and time, thus is valued appropriately. The survey supports a value between the two new patient office visits and the RUC agrees CPT code 99304 is in the proper rank order among other similar services.

For additional support, the RUC referenced MPC code 95861 *Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 29 minutes of intra-service time) and code 74181 *Magnetic resonance (eg, proton) imaging, abdomen; without contrast material(s)* (work RVU = 1.46 and 20 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 1.50 for CPT code 99304.**

99305 ***Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.***
The RUC reviewed the survey results from 204 physicians and determined that the survey 25th percentile work RVU of 2.50 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes of pre-service time, 35 minutes of intra-service time and 10 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU = 2.60, 40 minutes intra-service time and 60 minutes total time) and determined that 99305 requires slightly less physician work and time to perform.

The RUC also compared 99305 to the second top key reference service, 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.* (work RVU = 1.60, 25 minutes intra-service time and 35 minutes total time) and determined that 99305 requires much more physician work and time than 99203. The survey supports a value between the two new patient office visits and the RUC agrees CPT code 99305 is in the proper rank order among other similar services.

For additional support, the RUC referenced MPC code 95810 *Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist* (work RVU = 2.50 and 36.5 minutes of intra-service time) and code 75574 *Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)* (work RVU = 2.40 and 30 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 2.50 for CPT code 99305.**

99306 ***Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.***
The RUC reviewed the survey results from 208 physicians and determined that the survey 25th percentile work RVU of 3.50 appropriately accounts for the work required to perform this service. The RUC recommends 15 minutes of pre-service time, 50 minutes of intra-service time and 15 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50, 59 minutes intra-service time and 88 minutes total time) and determined that these services require the same physician work and should be valued the same. Although 99306 requires slightly less physician time, both require a high level of medical decision making and similar typical patients who require intensive management.

For additional support, the RUC referenced MPC code 90962 *End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month* (work RVU = 3.57 and 70 minutes of intra-service/total time) and code 50328 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; arterial anastomosis, each* (work RVU = 3.50 and 45 minutes of intra-service/total time), which require similar physician work and time. **The RUC recommends a work RVU of 3.50 for CPT code 99306.**

SUBSEQUENT NURSING FACILITY CARE

99307 ***Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.***
The RUC reviewed the survey results from 196 physicians and determined that the survey 25th percentile work RVU of 0.70 appropriately accounts for the work required to perform this service. The RUC recommends 1 minutes of pre-service time, 12 minutes of intra-service time and 1 minute of post-service time.

The RUC compared the surveyed code to the top key reference service 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter* (work RVU = 0.70, 11 minutes intra-service time and 16 minutes total time) and determined that these services require the same straightforward level of medical decision making, the same physician work and similar physician time to perform, thus should be valued the same.

The RUC also compared 99307 to the second top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter* (work RVU = 1.30, 20 minutes intra-service time and 40 minutes total time) and determined that 99307 requires much less physician work, time and a lower level of medical decision making, thus is valued appropriately.

For additional support, the RUC referenced MPC code 95251 *Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report* (work RVU = 0.70 and 15 minutes of intra-service time) and code 62368 *Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming* (work RVU = 0.67 and 15 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 0.70 for CPT code 99307.**

99308 ***Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.***
The RUC reviewed the survey results from 214 physicians and determined that the survey 25th percentile work RVU of 1.30 appropriately accounts for the work required to perform this service. The RUC recommends 5 minutes of pre-service time, 18 minutes of intra-service time and 4 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter* (work RVU = 1.30, 20 minutes intra-service time and 40 minutes total time) and determined that these services require the same low level of medical decision making, the same physician work and similar physician time to perform.

The RUC also compared 99308 to the second top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter* (work RVU = 1.92, 30 minutes intra-service time and 47 minutes total time) and determined that 99308 requires less physician work, time and level of medical decision making to perform than 99214, thus is valued appropriately.

For additional support, the RUC referenced MPC code 74170 *Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.40 and 18 minutes of intra-service time) and code 74280 *Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered* (work RVU = 1.26 and 20 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 1.30 for CPT code 99308.**

99309 ***Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***
The RUC reviewed the survey results from 217 physicians and determined that the 25th percentile work RVU of 1.92 appropriately accounts for the work required to perform this service. The RUC recommends 7 minutes of pre-service time, 30 minutes of intra-service time and 10 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter* (work RVU = 1.92, 30 minutes intra-service time and 47 minutes total time) and determined that these services require the same moderate level of medical decision making, physician work and physician time to perform.

The RUC also compared 99309 to the second top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter* (work RVU = 2.80, 45 minutes intra-service time and 70 minutes total time) and determined that 99309 requires less physician work, time and level of decision making, thus is valued appropriately.

For additional support, the RUC referenced MPC code 94002 *Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day* (work RVU = 1.99 and 30 minutes of intra-service time) and code 95957 *Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)* (work RVU = 1.98 and 30 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 1.92 for CPT code 99309.**

99310 *Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.*
The RUC reviewed the survey results from 203 physicians and determined that the survey 25th percentile work RVU of 2.80 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes of pre-service time, 45 minutes of intra-service time and 15 minutes of post-service time.

The RUC compared the surveyed code to the top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter* (work RVU = 2.80, 45 minutes intra-service time and 70 minutes total time) and determined that these services require the same high level of medical decision making, physician work and physician time to perform, thus should be valued the same.

The RUC also compared 99310 to the second top key reference service 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes* (work RVU = 4.50, 40 minutes intra-service time and 70 minutes total time) and determined 99310 requires less physician work and the typical patient is less intense than the critical care service. Thus, CPT code 99310 is appropriately valued lower than 99291.

For additional support, the RUC referenced MPC code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter* (work RVU = 2.60 and 40 minutes of intra-service time) and code 75561 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences;* (work RVU = 2.60 and 45 minutes of intra-service time), which require similar physician work and time. **The RUC recommends a work RVU of 2.80 for CPT code 99310.**

NURSING FACILITY CARE DISCHARGE DAY MANAGEMENT

99315 ***Nursing facility discharge day management; 30 minutes or less***
99316 ***Nursing facility discharge day management; more than 30 minutes***
The RUC reviewed CPT codes 99315 and 99316 and determined to maintain the proper rank order, these services should be reviewed with the hospital discharge day management codes, 99238 and 99239, in October 2021**. The RUC recommends to table review of CPT codes 99315 and 99316 until October 2021.**

CPT Descriptor Time
The RUC recommends the following times for the CPT descriptors based on the survey medians. The time in the CPT descriptors are rounded or incremental between this family of services for the ease of those who may report these services based on time.

CPT Code		Time on the Date of Encounter Recommendation to CPT
99304	Initial nursing facility care, per day, straightforward or low MDM	**25**
99305	Initial nursing facility care, per day, moderate MDM	**35**
99306	Initial nursing facility care, per day, high MDM	**45**
99307	Subsequent nursing facility care, per day, straightforward MDM	**10**
99308	Subsequent nursing facility care, per day, low MDM	**15**
99309	Subsequent nursing facility care, per day, moderate MDM	**30**
99310	Subsequent nursing facility care, per day, high MDM	**45**

Practice Expense
The Practice Expense Subcommittee approved the direct practice expense inputs as recommended by the specialty societies without modification. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation

Evaluation and Management

Nursing Facility Services

The following codes are used to report evaluation and management services to patients in nursing facilities and skilled nursing facilities ~~(formerly called skilled nursing facilities [SNFs], intermediate care facilities [ICFs], or long-term care facilities [LTCFs])~~. These codes should also be used to report evaluation and management services provided to a patient in a psychiatric residential treatment center and intermediate care facility for individuals with intellectual disabilities. ~~(a facility or a distinct part of a facility for psychiatric care, which provides a 24-hour therapeutically planned and professionally staffed group living and learning environment). If procedures such as medical psychotherapy are provided in addition to evaluation and management services, these should be reported in addition to the evaluation and management services provided.~~

~~Nursing facilities that provide convalescent, rehabilitative, or long-term care are required to conduct comprehensive, accurate, standardized, and reproducible assessments of each resident's functional capacity using a Resident Assessment Instrument (RAI). All RAIs include the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs), and utilization guidelines. The MDS is the primary screening and assessment tool; the RAPs trigger the identification of potential problems and provide guidelines for follow-up assessments.~~

Regulations pertaining to the care of nursing facility residents govern the nature and minimum frequency of assessments and visits. These regulations also govern who may perform the initial comprehensive visits.

These services are performed by the principal physician(s) and other qualified health care professional(s), overseeing the care of the patient in the facility. The principal physician is sometimes referred to as the admitting physician and is the physician who oversees the patient's care as compared to other physicians or other qualified health care professionals who may be furnishing specialty care. These services are also performed by physicians or other qualified health care professionals in the role of a specialist performing a consultation or concurrent care. Modifiers may be required to identify the role of the individual performing the service.

~~Physicians have a central role in assuring that all residents receive thorough assessments and that medical plans of care are instituted or revised to enhance or maintain the residents' physical and psychosocial functioning. This role includes providing input in the development of the MDS and a multi-disciplinary plan of care, as required by regulations pertaining to the care of nursing facility residents.~~

Two major subcategories of nursing facility services are recognized: Initial Nursing Facility Care and Subsequent Nursing Facility Care. Both subcategories apply to new or established patients.

The types of care (eg, skilled nursing facility and nursing facility care) are reported with the same codes. Place of service codes should be reported to specify the type of facility (and care) where the service(s) are performed.

*For definitions of commonly used terms, see **Evaluation and Management Services Guidelines.***

When selecting a level of medical decision making (MDM) for nursing facility services, the Nature and Complexity of Problems Addressed at the Encounter is considered. For this determination, a high level MDM type specific to Initial Nursing Facility Care by the principal physician or other qualified health care professional is recognized. This type is:

Multiple morbidities requiring intensive management: A set of conditions, syndromes or functional impairments that are likely to require frequent medication changes or other treatment changes and/or re-evaluations. The patient is at significant risk of worsening medical (including behavioral) status and risk for (re)admission to a hospital.

The definitions and requirements related to the Amount and Complexity of Data to be Reviewed and Analyzed and the Risk of Complications and/or Morbidity or Mortality of Patient Management are unchanged.

~~(For care plan oversight services provided to nursing facility residents, see 99379-99380)~~

Initial Nursing Facility Care
New or Established Patient

When the patient is admitted to the nursing facility in the course of an encounter in another site of service (eg, hospital emergency department, office), the services in the initial site may be separately reported. Modifier 25 may be added to the other evaluation and management service to indicate a significant, separately identifiable service by the same physician or qualified health care professional was performed on the same date. ~~all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial nursing facility care when performed on the same date as the admission or readmission. The nursing facility care level of service reported by the admitting physician should include the services related to the admission he/she provided in the other sites of service as well as in the nursing facility setting.~~

In the case when services in a separate site are reported and the initial nursing facility care service is a consultation service by the same physician or other qualified health care professional and reported on the same date, do not report 99304, 99305, 99306, 99252, 99253, 99254, 99255. The consultant reports the subsequent nursing facility care codes 99307, 99308, 99309, 99310 for the second service on the same date.

Hospital inpatient ~~discharge~~ or observation discharge services performed on the same date of nursing facility admission or readmission may be reported separately. For a patient discharged from inpatient or observation status on the same date of nursing facility admission or readmission, the hospital or observation discharge services ~~should~~ may be reported with codes 99238, 99239 as appropriate. ~~For a patient discharged from observation status on the same date of nursing facility admission or readmission, the observation care discharge services should be reported with code 99217.~~ For a patient admitted and discharged from observation or inpatient status on the same date, see codes 99234- 99236. Time related to ~~these~~ hospital inpatient or observation care services may not be used for code selection of any nursing facility service.

~~(For nursing facility care discharge, see 99315, 99316)~~

Initial nursing facility care codes 99304, 99305, 99306 may be used once per admission, per physician or other qualified health care professional, regardless of length of stay. They may be used for the initial comprehensive visit performed by the principal physician or other qualified health care professional. Skilled nursing facility initial comprehensive visits must be performed by a physician. Qualified health care professionals may report initial comprehensive nursing facility visits for nursing facility level of care patients, if allowed by state law or regulation. The principal physician or qualified health care professional may work with others (who may not always be in the same group) but are overseeing the overall medical care of the patient, in order to provide

timely care to the patient. Medically necessary assessments conducted by these professionals prior to the initial comprehensive visit are reported using subsequent care codes (99307, 99308, 99309, 99310).

Initial services by other physicians and other qualified health care professionals who are performing consultations may be reported using initial nursing facility care codes (99304, 99305, 99306) or inpatient consultations (99252, 99253, 99254, 99255). This is not dependent upon the principal care professionals completion of the initial comprehensive services first.

An initial service may be reported when the patient has not received any face-to-face professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses or physician assistants are working with physicians they are considered as working in the exact same specialty and subspecialty as the physician. An initial service may also be reported if the patient is a new patient as defined in the Evaluation and Management Guidelines.

For reporting initial nursing facility care, transitions between skilled nursing facility level of care ad nursing facility level of care do not constitute a new stay.

~~***Coding Tip***~~

~~**The Significance of Time as a Factor in Selection of an Evaluation and Management Code from This Section**~~

~~The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services included in codes in this section. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.~~

~~**Unit/floor time (hospital observation services [99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236], hospital inpatient services [99221, 99222, 99223, 99231, 99232, 99233], inpatient consultations [99251, 99252, 99253, 99254, 99255], nursing facility services [99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318]):**~~

~~For coding purposes, time for these services is defined as unit/ floor time, which includes the time present on the patient's hospital unit and at the bedside rendering services for that patient. This includes the time to establish and/or review the patient's chart, examine the patient, write notes, and communicate with other professionals and the patient's family.~~

~~CPT Coding Guidelines, Evaluation and Management, Guidelines Common to All E/M Services, Time~~

▲99304	I1	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. ~~these 3 key components:~~ ~~• **A detailed or comprehensive history;**~~ ~~• **A detailed or comprehensive examination; and**~~ ~~• **Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.	XXX	1.50
▲99305	I2	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ ~~• **A comprehensive history;**~~ ~~• **A comprehensive examination; and**~~ ~~• **Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.	XXX	2.50

▲99306	I3	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. (For services 60 minutes or longer, use prolonged services code 993X0)	XXX	3.50
Subsequent Nursing Facility Care ~~All levels of subsequent nursing facility care include reviewing the medical record and reviewing the results of diagnostic studies and changes in the patient's status (ie, changes in history, physical condition, and response to management) since the last assessment by the physician or other qualified health care professional.~~				
▲99307	I4	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A problem focused interval history;**~~ • ~~**A problem focused examination;**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.	XXX	0.70

▲99308	I5	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**An expanded problem focused interval history;**~~ • ~~**An expanded problem focused examination;**~~ • ~~**Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	XXX	1.30
▲99309	I6	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A detailed examination;**~~ • ~~**Medical decision making of moderate complexity**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	XXX	1.92

▲99310	I7	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A comprehensive interval history;**~~ • ~~**A comprehensive examination;**~~ • ~~**Medical decision making of high complexity**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. (For services 60 minutes or longer, use prolonged services code 993X0)	XXX	2.80
Nursing Facility Discharge Services The nursing facility discharge day management codes are to be used to report the total duration of time spent by a physician or other qualified health care professional for the final nursing facility discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the nursing facility stay, even if the time spent on that date is not continuous. Instructions are given for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. These services require a face-to-face encounter ~~but~~ that may be performed on a calendar date prior to the actual discharge date. The time of the face-to-face encounter performed on a date prior to the discharge date is counted toward 99315, 99316 and not reported separately.				
(f)99315	I8	*Nursing facility discharge day management; 30 minutes or less*	XXX	Tabled until October 2021 RUC Meeting
(f)99316	I9	*more than 30 minutes*	XXX	Tabled until October 2021 RUC Meeting

Other Nursing Facility Services				
~~D99318~~	-	~~Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making that is of low to moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.~~ ~~(Do not report 99318 on the same date of service as nursing facility services codes 99304-99316)~~ (99318 has been deleted. To report, see 99307, 99308, 99309, 99310)	~~XXX~~	~~N/A~~ (2021 work RVU = 1.71)

CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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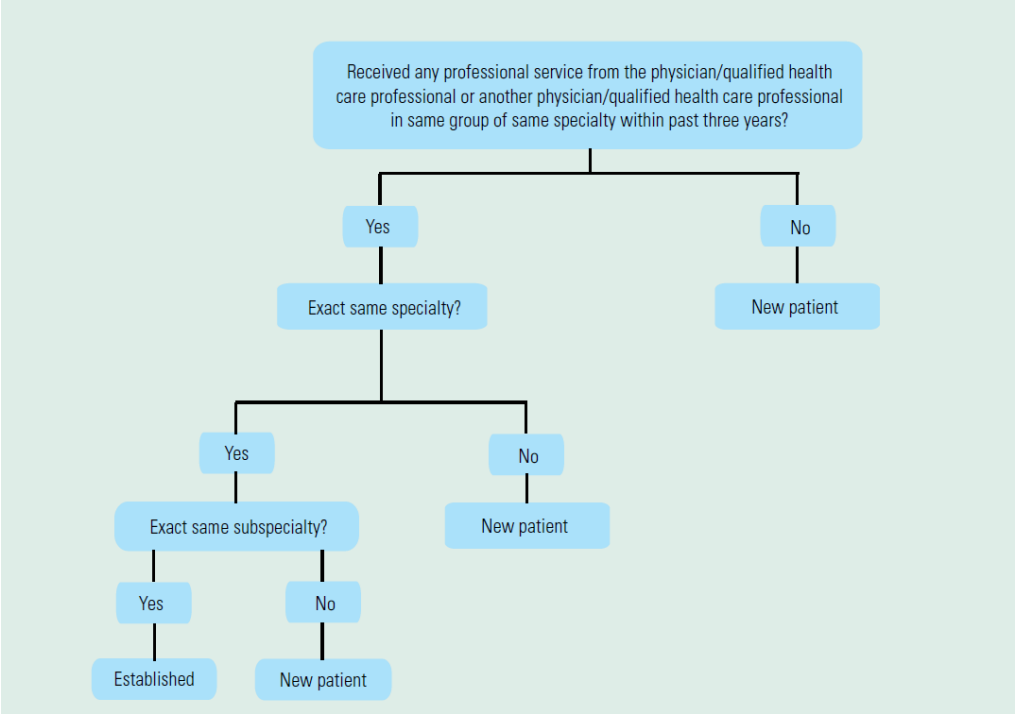
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99304 Tracking Number I1 Original Specialty Recommended RVU: **1.60**
Presented Recommended RVU: **1.50**
Global Period: XXX Current Work RVU: **1.64** RUC Recommended RVU: **1.50**

CPT Descriptor: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial nursing facility visit for a patient with limited supports at home receiving post-acute care for an operative procedure that was uncomplicated.

Percentage of Survey Respondents who found Vignette to be Typical: 79%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see patient; review medical records, and communicate with other health professionals as necessary.

Description of Intra-Service Work: Obtain a detailed history and fluid intake and other health conditions from patient's family, assisted living staff, and other health care professionals as necessary. Vital signs are noted. Perform a comprehensive physical examination that includes inspecting skin for pre-ulcerations and ulcerations; evaluating patients oral hygiene; cardiovascular, pulmoary, abdominal and genitourinary (GU) exams for evidence of obstructive urinary retention and fecal impaction; evauating patient's ability to communicate; and assessing safety of patient's gait.

Description of Post-Service Work: Follow up with telehpone calls to the facility regarding diagnostic findings, intraservice coordination and documentation of care, and interaction with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discuss with family and/or surrogate decsion maker the preferred intensity of care as it relates to do not resuscitate (DNR) orders for this patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99304					
Sample Size:	8275	**Resp N:**	203			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**2.00**	12.00	1150.00	
Survey RVW:	0.50	1.50	**1.70**	2.00	30.00	
Pre-Service Evaluation Time:			**6.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	0.00	20.00	**25.00**	30.00	120.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99304	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**6.00**	**0.00**	**6.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**25.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99202	XXX	0.93	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99203	XXX	1.60	**RUC Time**	11,452,897

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
78072	XXX	1.60	**RUC Time**	12,267

CPT Descriptor 2 Parathyroid planar imaging (including subtraction, when performed); with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization

Other Reference CPT Code	Global	Work RVU	Time Source
70492	XXX	1.62	**RUC Time**

CPT Descriptor Computed tomography, soft tissue neck; without contrast material followed by contrast material(s) and further sections

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 86 **% of respondents:** 42.3 **%**

Number of respondents who choose 2nd Key Reference Code: 46 **% of respondents:** 22.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99304	**Top Key Reference CPT Code:** 99203	**2nd Key Reference CPT Code:** **99202**
Median Pre-Service Time	6.00	5.00	2.00
Median Intra-Service Time	25.00	25.00	15.00
Median Immediate Post-service Time	5.00	5.00	3.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**36.00**	**35.00**	**20.00**

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	3%	44%	48%	5%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	48%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	3%	71%	26%
Physical effort required	2%	59%	39%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	40%	53%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	52%	39%	9%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	48%	48%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	67%	29%
Physical effort required	7%	50%	43%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	52%	48%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

The expert panel reviewed the initial visit code 99304.

99304 requires straightforward or low-level medical decision making or is based on total time spent on the date of the encounter. There were 203 respondents of whom 79% found the vignette to be typical. The survey times and median work RVU were 6/25/5/36/1.70. The 25th percentile work RVU was 1.5. The key reference services were 99203, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter, with times and work RVU of 5/25/5/35/1.6, and 99202, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter, with times and work RVU of 2/15/3/20/0.93.

The expert panel reviewed the current times and work RVU for 99304, 10/23/10/43/1.64.

The panel agreed that while the survey median intra-service time was two minutes higher than the current intra-service time, the total time has decreased by seven minutes. In addition, the survey median intra-service time and total time were practically identical to 99203, the most commonly chosen reference service. Based on the survey times, the expert panel determined a crosswalk to the key reference service, 99203 would result in the most accurate valuation. Therefore, the expert panel recommends for 99304, times and work RVU of 6/25/5/36/1.60.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4
99307	12	14	0.70

99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99304

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Podiatry How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Nurse Practitioner How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 449940
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for private and self-pay patients.

Specialty Podiatry Frequency 102586 Percentage 22.79 %

Specialty Family medicine Frequency 82789 Percentage 18.40 %

Specialty Internal Medicine Frequency 56242 Percentage 12.49 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 336,776 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC Database

Specialty Podiatry Frequency 76785 Percentage 22.80 %

Specialty Family Medicine Frequency 61967 Percentage 18.40 %

Specialty Internal Medicine Frequency 42097 Percentage 12.50 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99304

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99305 Tracking Number I2 Original Specialty Recommended RVU: **2.50**
Presented Recommended RVU: **2.50**
Global Period: XXX Current Work RVU: **2.35** RUC Recommended RVU: **2.50**

CPT Descriptor: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial nursing facility visit for a patient recovering from an illness or acute injury that requires ongoing medical management of their multiple stable problems.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review medical records, laboratory results, and diagnostic findings. Communicate with facility health care professionals as necessary.

Description of Intra-Service Work: Obtain a comprehensive patient history and perform a comprehensive physical examination. Review patient's intake and hydration status, postoperative condition, initial rehabilitation results, and status of recent urosepsis and pressure ulcer. Evaluate status of patient's multiple chronic health problems. Examine patient's vision and hearing and neurological examination. Develop a multidisciplinary plan of care that includes physical therapy (PT) and occupational therapy (OT) services, initiation of a pressure wound care program, adjustments in diet, weaning off catheter, re-titration of medications, evaluation of dietary and fluid intake, and monitoring for mental status changes due to changes in environment.

Description of Post-Service Work: Follow up with telephone calls to patient's orthopedist and to SNF facility regarding diagnotic findings, post-service coordination and documentation of care, and interaction with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discuss with family and/or surrogate decision maker the preferred intensity of care as it relates to DNR orders for this patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99305					
Sample Size:	5903	**Resp N:**	204			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	5.00	**21.00**	82.00	962.00	
Survey RVW:	0.75	2.50	**2.75**	3.00	4.75	
Pre-Service Evaluation Time:			**10.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	6.00	25.00	**35.00**	45.00	180.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99305	**Recommended Physician Work RVU: 2.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**35.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-49 mintues of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selction, 30-44 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.60	**RUC Time**	10,714,246

CPT Descriptor 1 Office or outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-49 mintues of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95810	XXX	2.50	**RUC Time**	272,131

CPT Descriptor 2 Polysomnography; age 6 or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist

Other Reference CPT Code	Global	Work RVU	Time Source
75574	XXX	2.40	**RUC Time**

CPT Descriptor Computed tomographic angiography, heart, coronary arteries and bypass grafts (when present), with contrast material, including 3D image postprocessing (including evaluation of cardiac structure and morphology, assessment of cardiac function, and evaluation of venous structures, if performed)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 108 **% of respondents:** 52.9 **%**

Number of respondents who choose 2nd Key Reference Code: 25 **% of respondents:** 12.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 99305	**Top Key Reference CPT Code:** 99204	**2nd Key Reference CPT Code:** **99203**
Median Pre-Service Time	10.00	10.00	5.00
Median Intra-Service Time	35.00	40.00	25.00
Median Immediate Post-service Time	10.00	10.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**55.00**	**60.00**	**35.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	2%	24%	57%	17%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	5%	31%	64%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	3%	54%	43%
Physical effort required	3%	51%	46%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	27%	70%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	36%	44%	16%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	48%	48%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	72%	20%
Physical effort required	0%	56%	44%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	36%	56%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review
The panel reviewed 99305.

99305, requires moderate level medical decision making or is based on total time spent on the date of the encounter. There were 204 respondents of whom 90% found the vignette to be typical. The survey times and median work RVU were 10/35/10/55/2.75. The 25th percentile work RVU was 2.50. The key reference services were 99204, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/40/10/60/2.60, and 99203, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter, with times and work RVU of 5/25/5/35/1.6.

The expert panel noted that the current times and work RVU for 99305 are 11/33/13/57/2.35.

The panel agreed that the increased patient acuity in the nursing facility setting and the shortened length of stay in acute care hospitals before patients are discharged into the nursing home setting supported the survey 25th percentile work RVU of 2.50 and the times of 10/35/10/55/ The panel reviewed the data for the key reference services and agreed that 99202 describes a patient population that is significantly less acute and complex then the patient population described by 99305. The expert panel also agreed that a work RVU of 2.50 placed 99305 in proper rank order with 99204 which has a work RVU of 2.60, a total time of 60 minutes and an intra-time of 40 minutes.

Therefore, the panel recommends times and work RVU of 10/35/10/55/ 2.50

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4

99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99305

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine How often? Sometimes

Specialty Family Medicine How often? Sometimes

Specialty Nurse Practitioner How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1333571
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volument and Medicaid volume plus an additional 10% estimated for private payors

Specialty Internal Medicine Frequency 397404 Percentage 29.79 %

Specialty Family Medicine Frequency 257379 Percentage 19.29 %

Specialty Nurse Practitioner Frequency 184033 Percentage 13.80 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,054,727 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC database

Specialty Internal Medicine Frequency 314309 Percentage 29.80 %

Specialty Family Medicine Frequency 203562 Percentage 19.29 %

Specialty Nurse Practitioner Frequency 145552 Percentage 13.79 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment
Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99305

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99306 Tracking Number I3 Original Specialty Recommended RVU: **3.50**
Presented Recommended RVU: **3.50**
Global Period: XXX Current Work RVU: **3.06** RUC Recommended RVU: **3.50**

CPT Descriptor: Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Initial nursing facility visit for a patient with multiple morbidities requiring intensive management

Percentage of Survey Respondents who found Vignette to be Typical: 93%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review medical records, laboratory results, and diagnostic findings. Communicate with facility health care professionals as necessary.

Description of Intra-Service Work: Obtain a comprehensive history and perform a comprehensive physical examination. Review patient's intake and hydration status and sliding scare insulin and psychotropic regimen. Discuss patient's multiple, still unstable, health problems with health care providers. Assess current status of cardiopilmonary function, swallowing and mobility function, and cognitive function. Review laboratory test findings including oxygenation, hydration, white blood cell count (WBC), cardiac rhythm, and glucose level trends. Initiate orders for O2, IV fluids, antibiotics, pain control, rehabilitation, and diagnostic testing to assess status. Develop a multidisciplinary care plan that includes PT, respiratory therapy (RT), and speech services; titration off insulin sliding scale; adjustments in diet and hydration; re-titration of psychotropic and analgesic medications; and monitoring for mental status changes.

Description of Post-Service Work: Follow up with telephone calls to the facility regarding diagnostic findings and intraservice coordination and documentation of care. Interact with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discuss with family and/or surrogate decision maker the preferred intensity of care as it relates to DNR orders for this patient.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99306					
Sample Size:	5903	**Resp N:**	208			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	10.00	**50.00**	150.00	1500.00	
Survey RVW:	1.00	3.50	**3.75**	4.00	5.90	
Pre-Service Evaluation Time:			**15.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	9.00	35.00	**50.00**	65.00	340.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99306	**Recommended Physician Work RVU: 3.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**50.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**0.00**	**15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status

Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:

Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99496	XXX	3.79	**RUC Time**

CPT Descriptor Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical Decision making of high complexity during the service period face-to-face visits, within 7 calendar days of discharge.

KEY MPC COMPARISON CODES:

Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.50	**RUC Time**	2,923,626

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90962	XXX	3.57	**RUC Time**	213,048

CPT Descriptor 2 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified helath care professional per month

Other Reference CPT Code	Global	Work RVU	Time Source
50328	XXX	3.50	**RUC Time**

CPT Descriptor Backbench reconstruction of cadavar or living donor renal alograft prior to transplant; atrial anastomosis, each

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 129 **% of respondents:** 62.0 **%**

Number of respondents who choose 2nd Key Reference Code: 30 **% of respondents:** 14.4 **%**

TIME ESTIMATES (Median)

	CPT Code: 99306	**Top Key Reference CPT Code:** 99205	**2nd Key Reference CPT Code:** **99496**
Median Pre-Service Time	15.00	14.00	0.00
Median Intra-Service Time	50.00	59.00	60.00
Median Immediate Post-service Time	15.00	15.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**80.00**	**88.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	2%	12%	36%	50%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	16%	81%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	38%	60%
Physical effort required	2%	44%	54%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	1%	14%	85%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	3%	0%	17%	33%	47%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	27%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	40%	53%
Physical effort required	3%	43%	54%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	10%	83%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting.

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

Next, the panel reviewed 99306 which requires a high level of medical decision making or is based on the total time spent on the date of the encounter. There were 208 respondents of whom 94% found the vignette to be typical. The survey times and median work RVU were 15/50/15/80/3.75 and the 25th percentile work RVU was 3.50. The two key reference services were, 99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter, with times and work RVU of 14/59/15/88/3.5 and, 99496, Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge of medical decision making, with times and work RVU of 0/75/0/75/3.79.

The expert panel noted that the current times and work RVU for 99306 were 15/45/20/80/3.06.

The panel noted that while the total time for 99306 remained the same, the intra-service time increased by 5 minutes (more than 10%). The panel also noted that while the total times and intra-service times were less than for 99205, the patient population and acuity supported a work value at least equal to 99205. Further 99496 has a lower total time than 99406 - but a greater intra time. And the survey median of 3.50 places 99306 in proper rank order with 99496. The panel also reviewed MPC code 90962, End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month, which is an MPC code and has times and work RVU of 0/70/0/70/3.57

The expert panel noted that 90962 has less total time than 99306 but more intra-service time and that the survey 25th percentile work RVU for 99306 of 3.50 places it in correct rank order with 90962 and the key reference services.

Therefore, the expert panel recommends times and work RVU of 15/50/15/80/3.50.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very

consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4
99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99306

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes
Specialty Nurse Practitioner	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1751100
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate is based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors.

Specialty Internal Medicine	Frequency 745969	Percentage 42.60 %
Specialty Family Medicine	Frequency 341464	Percentage 19.49 %
Specialty Nurse Practitioner	Frequency 171608	Percentage 9.80 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,389,990 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC database

Specialty Internal Medicine	Frequency 592136	Percentage 42.60 %
Specialty Family Medicine	Frequency 271048	Percentage 19.49 %
Specialty Nurse Practitioners	Frequency 136219	Percentage 9.79 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99306

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99307 Tracking Number I4 Original Specialty Recommended RVU: **0.70**
Presented Recommended RVU: **0.70**
Global Period: XXX Current Work RVU: **0.76** RUC Recommended RVU: **0.70**

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent nursing facility visit for a patient with a self-limited or minor problem.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review records of previously attempted interventions. Communicate with facility health care professionals as necessary.

Description of Intra-Service Work: Obtain an interval history that reveals ongoing poor dietary intake and urinary incontinence in a patient who cannot participate in pressure relief activities because of cognitive impairment. Perform a focused physical examination that reveals an improving lesion with no peripheral inflammation and no evidence of systemic involvement. As a result, alter patient's topical regimen, order a new nutritional program, and authorize a support surface.

Description of Post-Service Work: Follow-up with telephone calls to the facility

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99307					
Sample Size:	5903	**Resp N:**	196			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**10.00**	49.00	3000.00	
Survey RVW:	0.18	0.70	**0.80**	1.30	4.00	
Pre-Service Evaluation Time:			**1.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	0.00	10.00	**12.00**	15.00	120.00	
Immediate Post Service-Time:	**1.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99307	**Recommended Physician Work RVU: 0.70**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**1.00**	**0.00**	**1.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**12.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**1.00**	**0.00**	**1.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.70	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-19 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.70	**RUC Time**	10,729,531

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95251	XXX	0.70	**RUC Time**	248,288

CPT Descriptor 2 Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report

Other Reference CPT Code	Global	Work RVU	Time Source
62368	XXX	0.67	**RUC Time**

CPT Descriptor Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 130 **% of respondents:** 66.3 **%**

Number of respondents who choose 2nd Key Reference Code: 43 **% of respondents:** 21.9 **%**

TIME ESTIMATES (Median)

	CPT Code: 99307	**Top Key Reference CPT Code:** 99212	**2nd Key Reference CPT Code:** **99213**
Median Pre-Service Time	1.00	2.00	5.00
Median Intra-Service Time	12.00	11.00	20.00
Median Immediate Post-service Time	1.00	3.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**14.00**	**16.00**	**30.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	1%	7%	61%	27%	4%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	58%	29%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	74%	18%
Physical effort required	7%	68%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	5%	60%	35%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	9%	68%	21%	2%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	19%	51%	30%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	14%	67%	19%
Physical effort required	5%	70%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	9%	60%	31%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

The panel reviewed 99307, which requires straightforward medical decision making or is based on total time spent on the date of the encounter. There were 196 respondents of whom 89% found the vignette to be typical. The survey times and median work RVU were 5/10/5/20/0.76 and the 25th percentile work RVU was 0.70. The two key reference services were 99212, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter, with times and work RVU of 2/11/3/0.70, and 99213, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter, with times and work RVU of 5/20/5/30/1.30.

The expert panel noted that the current times and work RVU for 99307 are 5/10/5/20/0.76.

The panel agreed that while the survey intra-service time was two minutes higher than the current time, the total time decreased by six minutes. Furthermore, the survey intra-service time was one minute more than intra-service time for 99212 and the total time was two minutes less. Given the increased acuity of nursing home patients, the expert panel agreed that the 25th percentile work RVU of 0.70 - which is identical to that of 99212 - placed 99307 In proper rank order with 99212. In addition, the work value of 0.70 places 99307 in proper rank order with 99213 which has a total time more than twice the survey total time for 99307, an intra-service time 66% higher than the 99307 survey median and a work RVU 85% higher than the 25th percentile than the survey 25th percentile work RVU for 99307.

Therefore, the expert panel recommends times and work RVU for 99307 of 1/12/1/14/0/70.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4

99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99307

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner	How often? Sometimes
Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 4035247
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors

Specialty Nurse Practitioner	Frequency 1000741	Percentage 24.79 %
Specialty Internal Medicine	Frequency 823190	Percentage 20.39 %
Specialty Family Medicine	Frequency 702133	Percentage 17.40 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 2,372,760 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 medicare data from the RUC Database

Specialty Nurse Practitioner	Frequency 588444	Percentage 24.79 %
Specialty Internal Medicine	Frequency 484043	Percentage 20.39 %
Specialty Family Medicine	Frequency 412860	Percentage 17.39 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99307

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99308 Tracking Number I5 Original Specialty Recommended RVU: **1.30**
Presented Recommended RVU: **1.30**
Global Period: XXX Current Work RVU: **1.16** RUC Recommended RVU: **1.30**

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent nursing facility visit for a patient with a stable chronic illness or recovering from an acute uncomplicated injury.

Percentage of Survey Respondents who found Vignette to be Typical: 94%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review medical records. Communicate with other facility health care professionals as necessary.

Description of Intra-Service Work: Obtain an expanded history that includes intake and hydration information, discussion of the suprapubic-localized discomfort, muscle spasm, and psychosocial review of patient's coping ability with underlying disease. Perform an expanding physical examination, which reveals no evidence of dehydration, additional gross hematuria, or focal neurological findings, however, increased patient depression is observed. After necessary laboratory tests are ordered, patient is treated for the UTI and started on anti-depression medication.

Description of Post-Service Work: Follow up with telephone calls to the NF regarding titration of anti-depressant. Review confirming diagnostic laboratory data and antibiotic effectiveness. Discuss coordination and documentation of care and interaction with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99308					
Sample Size:	5903	**Resp N:**	214			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	20.00	**100.00**	350.00	6000.00	
Survey RVW:	0.50	1.30	**1.44**	1.85	5.00	
Pre-Service Evaluation Time:			**5.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	3.00	15.00	**18.00**	25.00	120.00	
Immediate Post Service-Time:	**4.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99308	**Recommended Physician Work RVU: 1.30**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**18.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**4.00**	**0.00**	**4.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99212	XXX	0.70	**RUC Time**	10,729,531

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74170	XXX	1.40	**RUC Time**	107,476

CPT Descriptor 2 Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections

Other Reference CPT Code	Global	Work RVU	Time Source
74280	XXX	1.26	**RUC Time**

CPT Descriptor Radiologic examination, colon, including scout absominal radiograph(s) and delayed image(s), when performed; double contrast (eg, high density barium and air) study, including glucagon, when administered

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 140 **% of respondents:** 65.4 **%**

Number of respondents who choose 2nd Key Reference Code: 38 **% of respondents:** 17.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 99308	**Top Key Reference CPT Code:** 99213	**2nd Key Reference CPT Code:** **99214**
Median Pre-Service Time	5.00	5.00	7.00
Median Intra-Service Time	18.00	20.00	30.00
Median Immediate Post-service Time	4.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**27.00**	**30.00**	**47.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	1%	47%	44%	8%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	56%	37%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	67%	29%
Physical effort required	4%	67%	33%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	48%	50%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	5%	55%	26%	13%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	13%	42%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	16%	58%	26%
Physical effort required	11%	55%	34%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	50%	45%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting.

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

The panel reviewed 99308 which requires low level medical decision making or is based on total time spent on the date of the encounter. There were 214 respondents of whom 95% found the vignette to be typical. The survey times and median work RVU were 5/18/4/27/1.44 with a 25th percentile work RVU of 1.30. The two key reference services were 99213, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter, with times and work RVU of 5/20/5/1.3, and 99214, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter, with times and work RVUs of 7/30/10/47/1.92.

The expert panel noted that the current times and work RVU for 99308 are 7/15/9/31/1.16.

The expert panel noted that while the survey median intra-service time was three minutes higher than the current time, the total time was four minutes less than the current time. Moreover, even though the total and intra-service time were slightly less than the comparable times for 99213 (the first key reference service), the increased acuity of nursing home patients supported an equivalent work RVU. Furthermore, the total and intra-service times for 99214 are 74% and 66% higher than the survey times for 99308 which supports a work RVU for 99308 of 1.30 which is 67% of the work value of 99214.

Therefore, the expert panel recommends times and work RVU for 99308 of 5/18/4/27/1.3.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4

99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99308

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner	How often? Sometimes
Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 15664105
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors

Specialty Nurse Practitioner	Frequency 5874039	Percentage 37.49 %
Specialty Internal Medicine	Frequency 3461039	Percentage 22.09 %
Specialty Family Medicine	Frequency 2036334	Percentage 13.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 11,312,117 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC Database, plus 10% from deleted code 99318.

Specialty Nurse Practitioner	Frequency 4239781	Percentage 37.47 %
Specialty Internal Medicine	Frequency 2499977	Percentage 22.09 %
Specialty Family Medicine	Frequency 1470575	Percentage 12.99 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99308

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99309 Tracking Number I6 Original Specialty Recommended RVU: **1.92**
Presented Recommended RVU: **1.92**
Global Period: XXX Current Work RVU: **1.55** RUC Recommended RVU: **1.92**

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent nursing facility visit for a patient with a new or progressing illness or acute injury that requires diagnostic evaluation, medical management or potential surgical treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review telephonic orders associated with recently reported URI; changes in dietary, bowel, and psychotropic regimens; and treatment of non-infected skin tear. Communicate with facility health care professionals as necessary..

Description of Intra-Service Work: Obtain a detailed interval history of each organ system that has an acute or active medical problem, including review of patient's multiple medications and recent laboratory and diagnostic testing ordered to evaluate patient's comprised respiratory condition. Perform a detailed physical examination and update the nursing plan of care.

Description of Post-Service Work: Evaluate additional diagnostic testing to determine hydration and pulmonary status and further changes in patient's psychotropic regimen. Follow up with telephone calls to facility staff, discussing coordination and documentation of care and interaction with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99309					
Sample Size:	5903	**Resp N:**	217			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	30.00	**100.00**	355.00	2000.00	
Survey RVW:	0.75	1.92	**2.09**	2.60	6.00	
Pre-Service Evaluation Time:			**7.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	5.00	20.00	**30.00**	35.00	120.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99309	**Recommended Physician Work RVU: 1.92**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter..

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter..

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99214	XXX	1.92	**RUC Time**	106,900,291

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter..

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
94002	XXX	1.99	**RUC Time**	3,816

CPT Descriptor 2 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

Other Reference CPT Code	Global	Work RVU	Time Source
95957	XXX	1.98	**RUC Time**

CPT Descriptor Digital analysis of electroencephalogram (EEG) (eg, for epileptic spike analysis)

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 149 **% of respondents:** 68.6 **%**

Number of respondents who choose 2nd Key Reference Code: 34 **% of respondents:** 15.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99309	Top Key Reference CPT Code: 99214	2nd Key Reference CPT Code: **99215**
Median Pre-Service Time	7.00	5.00	10.00
Median Intra-Service Time	30.00	30.00	45.00
Median Immediate Post-service Time	10.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**47.00**	**45.00**	**70.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	25%	54%	21%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	1%	36%	63%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	51%	47%
Physical effort required	0%	50%	50%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	1%	23%	75%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	15%	15%	50%	21%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	32%	59%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	9%	53%	39%
Physical effort required	6%	47%	47%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	21%	73%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

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The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

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2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
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After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

The expert panel reviewed 99309 which requires a moderate level of medical decision making or is based on the total time spent on the date of the encounter. There were 217 respondents of whom 86% found the vignette to be typical. The times and median work RVU were 7/30/10/47/2.09 and the 25th percentile work RVU was 1.92. The two key reference services were 99214, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter, with times and work RVUs of 7/30/10/47/1.92, and 99215, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/45/15/70/2.80.

The panel noted that the current times and work RVU for 99309 are 10/25/10/45/1.55.

The survey median intra time is five minutes longer than the current intra time and the total time is two minutes higher. Furthermore, the survey times and survey 25th percentile work RVU are identical to the times and work RVU for 99214, the key reference services chosen by 149 of the 217 respondents. Because the survey data for 99309 was a direct crosswalk to the key reference service at the 25th percentile the expert panel agreed to recommend the 25th percentile work RVU of 1.92. This also places 99309 in correct rank order to 99215 which has 50% more intra time (45 min. vs. 30 min.) and 49% more total time (70 min. vs. 47 min.) and 2.80 is 46% higher than 1.92.

Therefore, the expert panel recommends for 99309 times and work RVU of 7/30/10/47/1.92.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4

99307	12	14	0.70
99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the

provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99309

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner	How often? Sometimes
Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 13567069
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors

Specialty Nurse Practitioner	Frequency 6146335	Percentage 45.30 %
Specialty Internal Medicine	Frequency 2930703	Percentage 21.60 %
Specialty Family Medicine	Frequency 1628168	Percentage 12.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 10,094,874 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC Database plus 85% of deleted 99318

Specialty Nurse Practitioner	Frequency 4571968	Percentage 45.28 %
Specialty Internal Medicine	Frequency 2180492	Percentage 21.59 %
Specialty Family Medicine	Frequency 1222384	Percentage 12.10 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99309

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99310 Tracking Number I7 Original Specialty Recommended RVU: **2.80**
Presented Recommended RVU: **2.80**
Global Period: XXX Current Work RVU: **2.35** RUC Recommended RVU: **2.80**

CPT Descriptor: Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Subsequent nursing facility visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.

Percentage of Survey Respondents who found Vignette to be Typical: 90%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Prepare to see the patient. Review medical records and previously ordered diagnostic laboratory tests. Communicate with facility health care professionals as necessary.

Description of Intra-Service Work: Obtain a comprehensive history. Perform a comprehensive physical examination. Formulate a multidisciplinary treatment plan (MDM of moderate-complexity) that includes IV hydration and antibiotic therapy; nursing instructions regarding monitoring of respiratory, mental, functional, and diabetic status; respiratory and physical therapy assessments with treatment as indicated; and further laboratory monitoring to track effectiveness of treatment.

Description of Post-Service Work: Evaluate results of additionally ordered laboratory and diagnostic testing. Follow up with telephone calls to the facility to adjust interventions as indicated. Document coordination of care and interaction with facility health care professionals associated with delivery of care to this patient until the next face-to-face physician encounter. Discuss end-of-life issues with family members.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	04/2021					
Presenter(s):	Carlo Milani, MD, Tanvir Hussain, MD, Audrey Chun, MD, Charles Crecelius, MD, PhD, CMD, David Nace, MD, Korinne Van Keuren, DNP, APRN, Brooke Bisbee, DPM					
Specialty Society(ies):	AAPM&R, ACP, AGS, AMDA, ANA, APMA					
CPT Code:	99310					
Sample Size:	5903	**Resp N:**	203			
Description of Sample:	Random					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	2.00	**15.00**	50.00	1500.00	
Survey RVW:	1.00	2.80	**3.00**	3.60	7.00	
Pre-Service Evaluation Time:			**10.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	0.00	30.00	**45.00**	55.00	180.00	
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99310	**Recommended Physician Work RVU: 2.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**45.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**0.00**	**15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99291	XXX	4.50	**RUC Time**

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.80	**RUC Time**	10,388,878

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99204	XXX	2.60	**RUC Time**	10,714,246

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter

Other Reference CPT Code	Global	Work RVU	Time Source
75561	XXX	2.60	**RUC Time**

CPT Descriptor Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences

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RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 147 **% of respondents:** 72.4 **%**

Number of respondents who choose 2nd Key Reference Code: 19 **% of respondents:** 9.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 99310	**Top Key Reference CPT Code:** 99215	**2nd Key Reference CPT Code:** **99291**
Median Pre-Service Time	10.00	10.00	15.00
Median Intra-Service Time	45.00	45.00	40.00
Median Immediate Post-service Time	15.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**70.00**	**70.00**	**70.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	1%	21%	31%	47%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	1%	30%	69%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	44%	54%
Physical effort required	1%	45%	54%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	2%	22%	76%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	5%	42%	11%	42%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	32%	58%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	5%	58%	37%
Physical effort required	5%	58%	37%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	32%	68%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

The CPT codes for initial and subsequent nursing facility services were surveyed because the CPT editorial panel changed the descriptors of the codes so that the choice of code to report is based on either medical decision making or the total time spent on the date of the encounter. The total time will be based on the results of the surveys for each code. The CPT codes for discharge services were not changed by were surveyed because they are part of the nursing facility services family. CPT also deleted 99318 which was used to report annual nursing facility assessment because such assessments may be required by law. In the future these annual assessments will be reported using the appropriate initial or subsequent care code.

The codes were surveyed by the American Geriatrics Society (AGS), the American Medical Directors Association (AMDA), the American Academy of Physical Medicine & Rehabilitation (AAPM&R), the American Nurses Association (ANA), the American Podiatric Medical Association (APMA), and the American College of Physicians (ACP). The surveying societies convened an expert panel to review the survey results and make work and time recommendations to the RUC.

Compelling Evidence

The last time the nursing facility services codes were reviewed by the RUC was in February 2007. The expert panel reviewed peer-reviewed literature (see attached articles) that documented that there have been changes in physician work due to patient population and length of hospital stay. After its review the expert panel agreed that these codes met these compelling evidence criteria.

Specifically, the acuity of patients admitted to nursing home after being discharged from an acute care hospital has increased significantly from 2011 to 2018. The table below shows the increase in patient acuity upon hospital discharge (Elixhauser scale) and the Hierarchical Condition Category (HCC) score on SNF admission. Note that a SNF patient is the typical patient for nursing home visits.

All Hospital Discharges to SNFs

		Elixhauser		HCC	
Year	N	Mean/Estimate	Std. Error	Mean/Estimate	Std. Error
2011	2,617,881	8.839	0.006	2.028	0.001
2012	2,579,944	8.951	0.007	2.067	0.001
2013	2,585,660	9.102	0.007	2.107	0.001
2014	2,639,292	9.178	0.006	2.144	0.001
2015	2,696,494	9.346	0.006	2.205	0.001
2016	2,687,022	9.341	0.006	2.287	0.001
2017	2,742,833	9.554	0.006	2.358	0.001
2018	2,673,328	9.706	0.006	2.402	0.001

The Elixhauser index is a well-established tool that categorizes 30 patient comorbidities based on ICD diagnosis, in this case upon hospital discharge, and is used in a variety of ways including predicting adverse events and utilization of resources. The HCC is a risk adjustment model which calculates risk scores for aged and disable Medicare beneficiaries, often used to represent the expected costs of a Medicare member in the coming year. This data was supplied by Dr Vincent Mor, Brown University Center for Gerontology and Healthcare Research, using LTCFocus.org, a research data base from the Shaping Long-Term Care in America Project sponsored by Brown University and the National Institute on Aging.

Fashaw et. al. (JAMDA 21 (2020) 233-239, reviewed comprehensive data in US Nursing Homes from 1985-2015 and found that in 2015, as opposed to 1985, among other things, the resident cognitive function has decreased (e.g., percent of residents with dementia increased from 39% in 1995 to 45% in 2015), the percent of patients with a psychiatric diagnosis increased from 11% in 1995 to 31% in 2015, the percent of residents receiving antidepressants increased from 20% in 1995 to 49% in 2015, and the need to assistance with activities of daily living has increased,

Teno, et. al. (JAMA 2017) reviewed Medicare Part B claims data and showed that the care of SNF patients has shifted from physicians to nurse practitioners and physician assistances and that those physicians, NPs, and PAs who provide SNF care are SNFists - i.e., providers who bill more than 90% of all their visits in the nursing home setting.

Werner (JAMA 2018) reviewed MEDPAR data and determined that the length of acute care hospital stay before discharge to a post-acute facility decreased from 9.0 days in 2000 to 7.3 days in 2015 and length of stay in the post-acute care facility increased from 21.7 days in 2000 to more than 25 days in 2014 and 2015.

McCarthy et. al. (JAMA 2020) reviewed the nationwide Minimum Data Set (MDS) to look at transfers from nursing homes to acute care hospitals. They found that the number of transfers decreased from 2011 to 2016, especially for patients with dementia, heart failure, and chronic obstructive pulmonary disease - without an increased mortality rate in nursing homes.

After reviewing these data, the expert panel concluded that due to changes in patient population, changes in specialty mix, and the reduced length of acute care hospital stay before discharge to a nursing home, that the compelling evidence criteria were met.

Survey Data Review

The panel reviewed 99310 which requires high level medical decision making or is based on the total time spent on the day of the encounter. There were 203 respondents of whom 86% found the vignette to be typical. The survey times and median work RVU were 10/45/15/70/3.00 and the 25th percentile work RVU was 2.80. The two key reference services were 99215, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter, with times and work RVU of 10/45/15/70/2.80, and 99291, Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes, with times and work RVU of 15/40/15/70/4.5.

The expert panel noted that the current times and work RVU for 99310 are 15/35/20/70/2.35.

The expert panel noted that the survey intra time was 10 minutes longer than the current intra time even though the total time was the same. In addition, the survey times and 25th percentile RVU were identical to the times and work RVU for 99215 which was chosen as the key reference service by 147 of the 203 respondents. The survey times and 25th percentile work RVU also place 99310 in correct rank order with 99291 because while the times are similar, 99291 is much more intense service which is reflected by the work RVU for 99291 which is 60% higher then the recommended work RVU for 99310.

Therefore, the expert panel recommends for 99310, times and work RVU of 10/45/15/70/2.8.

Finally, the expert panel reviewed its recommendations for all the surveyed codes to determine whether the recommendations placed the codes in proper rank order with each other.

The panel reviewed the total times, intra times and work RVUs among the subsequent visit codes, among the initial visit codes, and between the discharge codes to determine if the ratios (i.e., percent) differences of those parameters were consistent. They were very consistent. The expert panel also reviewed these data for the comparable initial visit and subsequent visit codes (e.g., 99306 and 99310) to determine if the percent differences were consistent. They were very consistent. Similarly, the date between the two discharge codes were very consistent. The expert panel agreed that this analysis supported all the recommendations for time and work RVUs.

Code	Intra-time	Total Time	Work RVU
99304	25	36	1.6
99305	35	55	2.5
Ratio of 99305 to 99304	1.4	1.52	1.56
99305	35	55	2.5
99306	50	80	3.5
Ratio of 99306 to 99305	1.42	1.45	1.4
99307	12	14	0.70

99308	18	27	1.3
Ratio of 99308 to 99307	1.5	1.93	1.86
99308	18	27	1.3
99309	30	47	1.92
Ratio of 99309 to 99308	1.67	1.74	1.48
99309	30	47	1.92
99310	45	70	2.8
Ratio of 99310 to 99309	1.5	1.49	1.46
99304	25	36	1.6
99308	18	27	1.3
Ratio of 99308 to 99304	0.72	0.75	0.81
99305	35	55	2.5
99309	30	47	1.92
Ratio of 99309 to 99305	0.86	0.85	0.77
99306	50	80	3.5
99310	45	70	2.8
Ratio of 99310 to 99306	0.9	0.875	0.80
99315	25	40	1.5
99316	40	63	2.5
Ratio of 99316 to 99315	1.6	1.575	1.67

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. N/A

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99310

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner	How often? Sometimes
Specialty Internal Medicine	How often? Sometimes
Specialty Family Medicine	How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 2142752
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National estimate was based on total Medicare volume and Medicaid volume plus an additional 10% estimated for other payors

Specialty Nurse Practitioner	Frequency 1075661	Percentage 50.19 %
Specialty Internal Medicine	Frequency 402837	Percentage 18.79 %
Specialty Family Medicine	Frequency 227132	Percentage 10.60 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,676,670 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. Estimates are based on 2019 Medicare data from the RUC Database, plus 5% from deleted code 99318.

Specialty Nurse Practitioner	Frequency 841520	Percentage 50.18 %
Specialty Internal Medicine	Frequency 315046	Percentage 18.78 %
Specialty Family Medicine	Frequency 177727	Percentage 10.59 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Nursing home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99310

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

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Original Study

Thirty-Year Trends in Nursing Home Composition and Quality Since the Passage of the Omnibus Reconciliation Act

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Keywords:
Quality
Nursing Home Reform Act
OBRA 1987
nursing home characteristics

A B S T R A C T

Objective: In 1987, the Omnibus Reconciliation Act (OBRA) called for a dramatic overhaul of the nursing home (NH) quality assurance system. This study examines trends in facility, resident, and quality characteristics since passage of that legislation.
Methods: We conducted univariate analyses of national data on US NHs from 3 sources: (1) the 1985 National Nursing Home Survey (NNHS), (2) the 1992-2015 Online Survey Certification and Reporting (OSCAR) Data, and (3) LTCfocUS data for 2000-2015. We examined changes in NH characteristics, resident composition, and quality.
Setting and participants: US NH facilities and residents between 1985 and 2015.
Results: The proportion of NHs that are Medicare and Medicaid certified, members of chains, and operating not-for-profit has increased over the past 30 years. There have also been reductions in occupancy and increases in the share of residents who are racial or ethnic minorities, admitted for post-acute care, in need of physical assistance with daily activities, primarily supported by Medicare, and diagnosed with a psychiatric condition such as schizophrenia. With regard to NH quality, direct care staffing levels have increased. The proportion of residents physically restrained has decreased dramatically, coupled with changes in inappropriate antipsychotic (chemical restraint) use.
Conclusions and implications: Together with changes in the long-term care market, the NHs of today look very different from NHs 30 years ago. The 30th anniversary of OBRA provides a unique opportunity to reflect, consider what we have learned, and think about the future of this and other sectors of long-term care.

For more than 30 years, the quality of nursing home (NH) care has been a continuous concern.[1] In 1984, following published reports and concerns about resident abuse, neglect, and a lack of regulation and oversight, Congress asked the Institute of Medicine (IOM) to investigate the quality of NHs and make recommendations for improvement. The resulting report proposed radical NH reforms,[2] many of which were codified by Congress as part of the Nursing Home Reform Act of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987).

OBRA 1987 created regulations for NHs in an effort to improve the quality of care delivered to residents. OBRA included a minimum set of care standards and rights for people residing in Medicare- and Medicaid-certified NHs. OBRA 1987 had a focus on residents' quality of life and care, expectations for improved or maintained resident health, as well as residents' rights to banking, organized family councils, and freedom from unnecessary physical and chemical restraints. The Act also standardized certification standards and enforcement strategies. As such, OBRA 1987 was an overhaul of the NH industry and marked a new beginning for NH care and regulation.

In the 30+ years since OBRA 1987, there have been a number of other changes that have directly affected the NH industry. In response

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to consumer preferences to remain in the community, "age-in-place," and efforts to rebalance states' long-term care budgets,[3–5] there has been a considerable increase in home- and community-based services (HCBS). HCBS were seen as mechanisms to divert or delay expensive, and often undesired, NH placement. Over the last several decades, states have begun funding more HCBS, primarily through Medicaid waiver programs; and, for the first time in 2013, states spent more on HCBS than care provided in NHs.[6] Accompanying these care delivery, market, and financing changes has been growth of an aging and diversifying population, as well as a number of laws and regulations directly impacting the NH industry (eg, the Balanced Budget Act of 1997 and the introduction of case-mix reimbursement).

The purpose of this study was to summarize changes in the NH industry in the 30 years since the seminal regulatory change affecting NHs. Specifically, we use historical data from 3 national sources and describe changes in NH facility characteristics, resident characteristics, and quality of care from 1985 through 2015. The 30th Anniversary of OBRA provides a unique opportunity to examine the changes within this vitally important industry. This article can aid in understanding long-term trends, as well as provide insight into what changes we might expect in the future.

Methods

Data

We analyzed data from 3 sources to examine resident and facility characteristics, longitudinally: (a) National Nursing Home Survey, (b) Online Survey Certification and Reporting Data/Certification and Survey Provider Enhanced Reporting, and (c) LTCFocUS data.

National Nursing Home Survey (NNHS)

The National Center for Health Statistics conducted the NNHS. The NNHS consists of a nationally representative sample of more than 1,000 NHs and their residents. NHs included in the surveys had at least 3 or more beds and were Medicare or Medicaid certified or had a state license to operate as an NH. The facilities and residents were selected by a stratified 2-stage probability design. In the first stage, NHs were selected, and in the second stage, residents were sampled from the selected NHs. NNHS data were used to describe facility and aggregated resident characteristics. Data for these analyses came from the University of Michigan ICPSR public use NNHS data files for 1985.[7]

Online Survey Certification and Reporting Data (OSCAR)/ Certification and Survey Provider Enhanced Reporting (CASPER)

CMS' OSCAR/CASPER database is a national database of all NH data elements collected by state survey agencies during the required annual onsite Medicare and Medicaid Certification inspection. The inspections occur at least once during a 15-month period. OSCAR/CASPER data are used to determine facility characteristics, deficiencies in care noted during the survey, and aggregated resident data. Data included all certified NHs between the years 1992 and 2015. Variables in OSCAR/CASPER have been validated for research purposes.[8]

Long-Term Care FocUS (LTCFocUS)

We used LTCFocUS.org, a product of the Shaping Long-Term Care in America Project at the Brown University Center for Gerontology and Healthcare Research and supported, in part, by the National Institute on Aging (www.ltcfocus.org). This data set included information for years 2000-2015 and combined variables from the OSCAR data; the Minimum Data Set (MDS), resident-level data related to resident clinical and functional status; the Area Resource File (ARF), a national county-level health resources database maintained by the Health Resources and Services Administration that contains data about the health professionals and facilities in each county; and the Residential History File, a data resource built using Medicare Enrollment data, Medicare claims data, and assessment data to track individuals as they move through the long-term care system.[9] For these analyses, we used the LTCFocUS data to describe the aggregated characteristics of residents served in NHs between 2000 and 2015.

Variables

We included the following facility characteristics to describe changes in the NH market over time: dual certification for Medicare and Medicaid, multifacility chain membership, for-profit status (vs nonprofit or government), presence of an Alzheimer's special care unit, facility size (ie, total number of beds), and occupancy rate.

To describe the resident composition, we included demographic characteristics, length of stay, admission source, physical function, mental health diagnoses, and medication use measures. Demographic variables from LTCfocUS included the percentage of female residents in each facility; the percentage of blacks, whites, and Hispanics in each facility; and the average age for residents residing in each facility. Also from the LTCfocUS, we included the percentage of long-stay residents, defined as the percentage of residents in the NH at least 90 of the last 100 days. We also include the percentage of residents admitted to the NH directly from the hospital vs the community or other LTC setting. From the OSCAR/CASPER, we included information about residents' primary payer as the percentage of residents whose primary support was Medicaid or Medicare. Measures of resident physical and cognitive function included the facility's average Activities of Daily Living (ADL) scale score, bed/chair bound measures, individual early-, middle-, and late-loss ADL, and the percentage of residents with dementia. The ADL scale score comes from LTCFocUS, ranges from 0 to 28, and is created by summing 7 ADL items on a scale from 0 to 4 (with 0 = complete independence and 4 = total dependence for each item). The facility average represents the average across all residents in the facility. Chairbound and bedbound measures come from the NNHS and OSCAR/CASPER data and refer to the percentage of residents unable to leave their chair or bed, respectively, at the time of the survey. The individual ADL of interest from the NNHS and OSCAR/CASPER data include dressing, bathing, transferring, toileting, and eating, and represent the percentage of residents who were not completely independent in each of these activities at the time of the survey. From the NNHS and OSCAR/CASPER data, we also included a measure for the percentage of residents with dementia within the facility. Measures of resident mental health and medication use included the percentage of residents with a psychiatric diagnosis (excluding dementia and depression), a schizophrenia diagnosis, receiving antianxiety medications, receiving antidepressants, and receiving antipsychotics.

Information on facility quality consisted of structure, process, and outcome measures.[10] As a measure of structure, we included the number of certified nursing aides, licensed professional nurses, and registered nurse hours per resident per day from the OSCAR/CASPER data. We obtained information about facilities' quality process measures including the percentage of residents in a facility who were physically restrained, received tube feeding, had a catheter, received antipsychotic medications without a diagnosis of schizophrenia or bipolar disorder at the time of the survey, and the percentage of facilities experiencing medication errors. Medication error refers to the percentage of facilities cited for drug error rates higher than 5% reported during the annual survey. Quality outcome measures included the percentage of residents within a facility with pressure ulcers, and the percentage of residents within a facility experiencing incontinence. Values for pressure ulcers indicate the percentage of residents during the annual survey with pressure sores. The incontinence measures indicate the percentage of residents with bladder or bowel incontinence at the time of the survey.

Table 1
Changes Over Time in Facility Characteristics (1985-2015)

Year	1985, Mean (CI)	1995, % or Mean (SD)	2005, % or Mean (SD)	2015, % or Mean (SD)
Number of nursing homes, n	19,068*	16,824	16,091	15,686
Percentage dual (Medicare + Medicaid) certified	33.3 (28.9, 37.8)	78.6	93.4	97.1
Percentage member of a chain		51.24	52.43	56.81
Percentage for-profit	75.0 (70.9, 79.1)	66.4	66.0	69.1
Percentage with Alzheimer's Unit		11.2	18.2	15.2
Average number of beds		100.84 (67.93)	104.97 (65.37)	106.13 (61.31)
Percentage with 3-49 beds	33.7 (26.8, 41.0)	18.8	14.9	12.9
Percentage with 50-99 beds	32.4 (28.0, 36.8)	36.0	36.3	37.1
Percentage with 100-199 beds	27.8 (24.2, 31.5)	38.5	42.2	44.0
Percentage with ≥200 beds	6.1 (5.1, 7.2)	6.8	6.5	6.0
Average occupancy rate		87.14 (16.41)	84.43 (15.14)	81.19 (15.79)

CI, confidence interval; SD, standard deviation.
*Weighted number of facilities.
Source: The 1985 National Nursing Home Survey and the 1995, 2005, and 2015 Online Survey Certification and Reporting/Certification and Survey Provider Enhanced Reporting Data.

Analyses

Univariate analyses of the above variables were completed using Stata, version 14 (StataCorp, College Station, TX). Data from the NNHS were weighted using the facility, bed, and current resident weights provided. OSCAR/CASPER and LTCFocUS data are available at the facility level. Facility-level variables are averaged for each study year. We do not include inferential statistics in this article because we are presenting data for the entire population of NHs in the United States for the majority of years.

Results

Facility Characteristics

In the past 30 years, the NH industry has decreased in size, from 19,068 facilities in 1985 to 15,686 in 2016 (Table 1). There has also been an increase in the percentage of facilities that are nonprofit (25% in 1985 and 31% in 2015) and that are dually certified by both Medicare and Medicaid (33% in 1985 and up to 97% 2015). Between 1995 and 2015, chain membership increased from 51% to 57%, the percentage of facilities with an Alzheimer's special care unit increased from 11% to 15%, and the overall NH occupancy rates declined from 87% to 81%.

Resident Composition

The population that NHs serve has changed over the last 30 years (Table 2). Data from the NNHS and LTCFocUS suggest that although the average age of residents has remained constant, the percentage of residents who are racial and ethnic minorities has increased from 7.8% in 1985 to 20.7% in 2015. The average percentage of females decreased from 72% of residents in 1985 to 67% in 2015. The prevalence of long-stay residents within NHs has remained stable at 69% of all residents over this time period. However, the percentage of residents admitted from the hospital increased from 67% in 2000 to 85% in 2015. There has also been a shift of payer types over time (Figure 1). Between 1992 and 2015, the average percentage of residents with Medicaid as a primary payer decreased from 64% to 58%, whereas the average percentage of residents with Medicare as the primary payer rose from 9% to 15%.

Resident physical and cognitive function has decreased over the years (Table 3). According to LTCFocUS data, the average ADL dependency score among NH residents increased slightly, from 15 to 17, between 2000 and 2015. According to NNHS and OSCAR/CASPER data, residents who required assistance in bathing increased from a national average of 89% in 1985 to an average facility average of 96% in 2015. The same trend is demonstrated by the increased share of residents who need assistance with the other ADL from 1985 to 2015: assistance with dressing rose from 74% to 92%, assistance with transferring from 60% to 85%, assistance with toileting from 49% to 88%, and assisting with eating increased from 38% to 56%. However, there was a decrease in the percentage of residents who were bed-bound from 6% in 1985 to 4% in 2015, whereas being chair bound rose from 39% to 64%. The percentage of residents with dementia increased from an average of 39% in 1995 to an average of 45% across the facilities in 2015.

The share of residents with psychiatric diagnoses has increased over the years, as has the use of psychotropic medications. According to the OSCAR/CASPER data, there was an almost 3-fold increase in the share of residents with a psychiatric diagnosis, from 11% in 1995 to 31% by 2015. Between 1985 and 2015, the average percentage of

Table 2
Changes Over Time in Resident Demographics, Length of Stay, and Admission Source (1985-2015)

Year	1985, Mean (CI) (n = 1,489,508*)	2000, Mean (SD) (n = 16,824)	2005, Mean (SD) (n = 16,091)	2015, Mean (SD) (n = 15,686)
Percentage female	71.6 (70.3, 73.0)	72.1 (13.8)	70.9 (14.0)	66.7 (13.04)
Percentage black	7.0 (6.2, 7.8)	9.9 (17.8)	10.9 (18.5)	11.6 (18.0)
Percentage Hispanic	2.8 (2.3, 3.2)	2.9 (9.1)	3.4 (9.8)	4.5 (11.3)
Percentage white	92.2 (91.4, 93.0)	85.6 (21.3)	83.7 (22.6)	79.3 (24.0)
Average age, y	79.61 (79.21, 80)	80.95 (7.11)	80.15 (7.68)	79.71 (7.34)
Percentage long stay		69.3 (22.6)	70.6 (19.3)	68.6 (17.0)
Percentage admitted from the hospital		66.5 (22.9)	72.8 (21.5)	84.7 (17.2)

CI, confidence interval; SD, standard deviation.
NNHS data represent the weighted national averages, whereas LTCFocUS data represent the average of facility averages.
*Weighted number of residents.
Source: The 1985 National Nursing Home Survey(NNHS) and Brown University's LTCFocUS Data for 2000, 2005, and 2015.

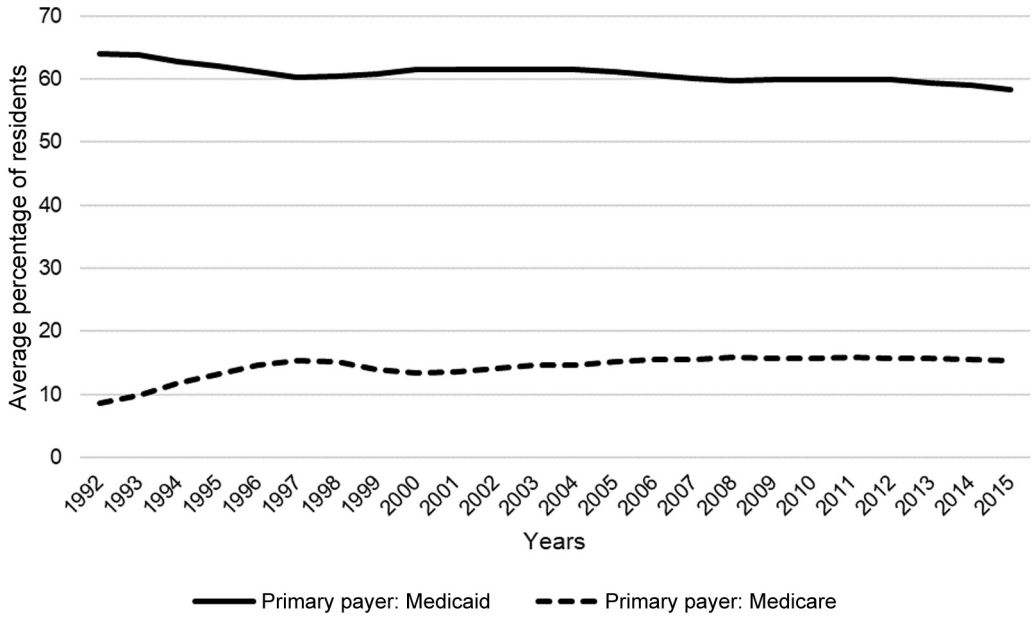

Fig. 1. Primary payment source using OSCAR/CASPER Data (1992-2015).

residents with schizophrenia increased from 6% to 11%. The percentages of residents receiving antianxiety, antidepressant, and antipsychotic medications in 1995 were 15%, 20%, and 16%, respectively, and by 2015 increased to 23%, 49%, and 20%, respectively.

Quality of Care

The average direct care staffing hours have increased over time, with the greatest increases observed among CNAs (see Table 4). Overall, quality process measures have also improved since the passage of OBRA 1987. Notably, the average proportion of residents being physically restrained decreased dramatically from 19% to 1%, and the percentage of residents receiving antipsychotic medications inappropriately, as a chemical restraint, decreased from 16% in 2000 to 12% in 2015, although there was a peak of 22% in 2005. However, there was not much change in the proportion of facilities cited for medication errors over this time period.

Quality outcome measures also improved over time. The proportion of residents with pressure ulcers decreased from 8% to 6%. Lastly, congruent with increased need for assistance, bowel and bladder incontinence increased from 42% to 44% and 49% to 62%, respectively.

Table 3
Changes Over Time in Resident Function, Mental Health, and Medication Use (1985-2015)

Year	1985, % (CI) (n = 1,489,508)*	1995/2000†, Mean (SD) (n = 16,824)	2005, Mean (SD) (n = 16,091)	2015, Mean (SD) (n = 15,686)
Physical and cognitive function				
Average Activities of Daily Living (ADL) Scale score†		15.26 (3.47)	15.60 (3.32)	16.87 (2.62)
Percentage of residents bed bound	6.5 (5.8, 7.2)	6.6 (9.9)	4.3 (7.4)	3.7 (6.9)
Percentage of residents chair bound	39.5 (38.1, 40.9)	48.1 (21.3)	55.1 (21.2)	64.3 (21.4)
Percentage of residents needing assistance with early-loss ADL				
Dressing	74.2 (72.8, 75.5)	86.6 (12.4)	88.2 (11.7)	91.8 (10.9)
Bathing	89.2 (88.1, 90.2)	94.2 (10.1)	95.4 (9.2)	96.5 (8.5)
Percentage of residents needing assistance with middle-loss ADL				
Transfer	60.2 (58.8, 61.7)	72.7 (16.5)	77.3 (15.4)	85.5 (14.7)
Toileting	49.2 (47.7, 50.6)	76.6 (15.0)	81.5 (13.9)	88.1 (13.0)
Percentage of residents needing assistance with late-loss ADL				
Eating	37.7 (36.3, 39.1)	53.0 (22.2)	49.4 (21.9)	56.5 (28.9)
Percentage of residents with dementia	43.3 (41.9, 44.8)	39.0 (20.0)	45.2 (19.4)	45.3 (18.4)
Mental health and medication use				
Percentage of residents with psychiatric diagnosis		11.2 (13.9)	19.8 (17.2)	31.4 (19.5)
Percentage of residents with schizophrenia†	5.7 (5.0, 6.4)	6.1 (9.9)	7.7 (11.0)	10.4 (13.0)
Percentage of residents receiving antianxiety medications		14.6 (10.2)	17.6 (10.3)	23.0 (11.6)
Percentage of residents receiving antidepressant medications		19.5 (10.9)	45.8 (14.3)	48.7 (14.5)
Percentage of residents receiving antipsychotic medication		16.0 (13.1)	26.0 (14.7)	20.1 (14.5)

CI, confidence interval; SD, standard deviation.
NNHS data represent the national averages, whereas OSCAR data represent the average of facility averages. The average ADL score is based on 7 ADL ranges from 0 to 28, where 0 = total independence and 28 = total dependence. The Average Acuity Index includes ADL and special treatment measures.[9]
*Weighted number of residents.
†These data are from the 2000, 2005, and 2015 LTCFocUs instead of the OSCAR/CASPER data.
Source: The 1985 National Nursing Home Survey (NNHS), the 1995, 2005, and 2015 Online Survey Certification and Reporting/Certification and Survey Provider Enhanced Reporting Data(OSCAR/CASPER), and the Brown University's LTCFocUS Data for 2000, 2005, and 2015.

Table 4
Changes Over Time in Quality Indicators (1995-2015)

Year	1995/2000*, Mean (SD) (n = 16,824)	2005, Mean (SD) (n = 16,091)	2015, Mean (SD) (n = 15,686)
Structure (staffing)			
CNA hours per resident day	2.26 (1.73)	2.30 (1.15)	2.42 (1.05)
LPN hours per resident day	0.87 (1.49)	0.84 (0.81)	0.88 (0.73)
RN hours per resident day	0.66 (1.64)	0.45 (0.86)	0.58 (0.87)
Direct care hours per resident day	3.39 (2.08)	3.48 (1.56)	3.79 (1.42)
Process			
Percentage of residents restrained	18.6 (17.2)	6.9 (8.7)	1.4 (4.9)
Percentage of residents receiving tube feeding	6.3 (8.5)	6.0 (8.4)	4.7 (8.2)
Percentage of residents with a catheter	8.3 (9.5)	7.0 (7.0)	5.9 (5.3)
Percentage of residents receiving inappropriate antipsychotic medication*	16.4 (9.4)	21.9 (10.2)	12.4 (7.6)
Percentage of facilities cited for medication errors ≥5%	1.5	1.8	1.7
Outcome			
Percentage of residents with pressure ulcers	7.6 (8.0)	7.4 (6.0)	6.2 (5.1)
Percentage of residents with bowel incontinence	41.8 (19.1)	42.9 (18.0)	43.9 (18.4)
Percentage of residents with bladder incontinence	49.3 (18.5)	53.5 (17.4)	62.1 (18.2)

CNA, certified nursing aide; LPN, licensed professional nurse; RN, registered nurse; SD, standard deviation.
*These data are from the 2000, 2005, and 2015 LTCFocUs instead of the OSCAR/CASPER Data.
Source: The 1995, 2005, and 2015 Online Survey Certification and Reporting/Certification and Survey Provider Enhanced Reporting Data (OSCAR/CASPER), and the 2000, 2005, and 2015 Brown University LTCFocUS Data.

Discussion

Within this 30-year period, there were facility, resident, and quality of care changes that can be linked to regulations adopted through the OBRA 1987 and other policy shifts in the long-term care sector.

Certification

Over the last 30 years, we witnessed a change in NH certification. This change is consistent with the OBRA 1987 requirement for NHs to be certified and meet the federal participation requirements in order to receive Medicaid and Medicare payments.[11] Previously, Medicare-certified facilities had more stringent requirements, but seeing that the majority of government spending came from Medicaid, OBRA 1987 stipulated that all Medicaid-certified facilities met a set of standards that were similar to that of Medicare.[1] Additionally, noting Medicare's generous reimbursement for skilled care, many Medicaid-only NHs became dually certified in both Medicare and Medicaid.[12] These policy and financing incentives likely contributed to the increase in the proportion of facilities that were dually certified during this time period.

Changing Demand and Supply, and Lower Occupancy

Concurrent with shifting US demographics (eg, an aging and increasingly diverse population), NHs in the last 30 years have witnessed increases in the proportion of minorities and decreases in the proportion of white residents. Recognizing the aging population, the long-term care market began to appear more lucrative and attracted a greater number of investors to NH operations.[13] This is evidenced by the percentage of NHs that were owned and operated by a chain. Stevenson, Grabowski, and Coots (2006) posit that chain facilities increased because of the interplay of certificate of need laws and resulting acquisitions.

Despite the aging of the population, there was a decrease in the number of NHs and facility occupancy rates during this time period. This decrease in NH supply and occupancy is likely attributable to the rise of community options such as assisted living and other HCBS.[14,15] In 2000, Medicaid spent about 27% of its total Medicaid long-term services and supports expenditures on HCBS and 73% on institutional care; by 2016, 57% of the expenditures were for HCBS and 43% for NH care.[6] It can be difficult to quantify the increase in community-based services due to data challenges; however, the National Survey of Resident Care Facilities identified approximately 31,100 residential facilities in 2010 and researchers have suggested a continued growth in the market.[16–18] The growth of long-term care alternatives allows individuals to remain in their homes and communities longer, in many cases delaying NH placement or diverting it altogether.[19–23] These trends may also explain some of the reasons behind the increase in functional impairment among NH residents over this time period.

Another potential explanation for the increase in functional impairment witnessed over this 30-year period may be the increase in post-acute, rehabilitative care provided in NHs. Recognizing the profitability associated with providing Medicare-reimbursed services,[24] NHs began to accept more post-acute care patients, with a large number of NHs choosing to specialize in the care of post-acute patients.[12,25] This shift in the orientation of NHs over this time period, from providing typically long-term custodial care to post-acute, rehabilitative care, may contribute to the increase in resident acuity witnessed in this study. It is evident from our findings that there is an increased percentage of residents being admitted directly from the hospital, presumably for post-acute care, which may contribute to higher levels of functional impairment as residents may be leaving hospitals "quicker and sicker."[26,27]

Quality Improvement

Despite higher resident levels of need, NH quality appears to have improved over time. Our data show modest gains in quality indicators between 1995 and 2015. The literature around drivers of quality improvement in NHs is vast and includes mechanisms such as NH ownership, nurse staffing, public reporting, and quality improvement initiatives. The quality improvement that we witnessed during this time period could have been attributable to the increase in nonprofit NHs, which have consistently shown to have higher quality ratings.[13] Quality improvement could also be directly related to the increase in nursing hours witnessed over this time period. OBRA 1987 improved the standards for nursing hours, and we observed these increases over time. Although it is possible that the increase in nursing hours may be in direct response to increasing need among residents, prior research has concluded that increasing nursing hours improves patient outcomes.[28–30] It is also plausible that new inspection, survey, enforcement efforts, and public reporting prompted improvements in quality

measures.[1,31] Although it can be argued that NHs still have room to improve in their quality indicators, it is important to note that despite an increasingly vulnerable and higher need population, we still observe quality gains among NHs during this time period.

One of the direct effects of OBRA 1987 was a substantial decrease in the use of physical restraints. Physical restraints were initially used on residents with serious mental illness to manage behaviors, but began to be used more widely on residents with behavioral symptoms, including residents with dementia.[32] Prior research indicates that physical restraints are associated with worse outcomes for residents, such as increased depression, less social engagement among NH residents,[33–35] reduced muscle strength,[33] and pressure ulcers.[33,34,36] Parts of OBRA 1987 focused directly on the residents' rights to be free from all restraints. Unfortunately, decreases in physical restraints were coupled with initial increases in chemical restraint use, such as inappropriate antipsychotic use. Antipsychotic medications increase the risk of falls[37] and death.[38,39] In 2005, the FDA released a Black Box warning to decrease the use of antipsychotics among older adults.[40] This warning is consistent with the 2005 peak in antipsychotic use that is present in our data. In 2011, CMS launched a national partnership to further reduce inappropriate antipsychotic use, which has been largely successful.[41] With the increase in dementia residents and initiatives to improve dementia care in NHs, there was a simultaneous increase in Alzheimer's SCUs, with a peak in the percentage of facilities with an Alzheimer's SCU in 2005. Literature suggests that residents within facilities with SCUs have significantly more challenging behaviors and have increased risk for chemical restraint use.[42,43] The presence of these units may also account for the increased resident impairment.

It is also important to note the dramatic increase in residents with serious mental illnesses (SMI), as this could be a direct result of state psychiatric facilities closures in the 1960s and 1970s. The increase in the SMI population creates a new and increased burden for NHs and their staff that may negatively affect the quality of care that NHs are able to provide.[44,45]

Despite the success of several prompted voiding interventions,[46,47] we observed increases into the share of NH residents experiencing incontinence over the past 30 years, potentially reflective of the increasing needs of the NH population. Prompting toileting interventions can be labor intensive, and it is often more convenient to diaper a resident than toilet.[48] More work is needed in this important quality of life area.

Limitations

This work provides a high-level look at national trends in NH characteristics, resident composition, and quality measures. Data are averaged across all facilities for the available study years. We do not have access to annual data available between 1986 and 1994, and because of the facility-level nature of our data we are unable to summarize resident-level changes over time. For example, it would be interesting to examine changes in acuity, separately for long-stay vs short-stay residents, or changes in residents' lengths of stay. This would help us understand if the increase in acuity over time is due to an increased focus on post-acute care, or attributable to higher levels of acuity among long-term residents who may delay entry into NHs through home- and community-based alternatives. Future work in this area would be beneficial to understanding additional impacts of OBRA on the long-term care industry as a whole.

Conclusions and Implications

Overall, OBRA 1987 is positively associated with the quality of care improvements in NHs despite increasing impairment of NH residents. OBRA 1987 was also successful in implementing and enforcing the MDS resident assessment survey, and without that this research would not be possible. Because of the aging-in-place movement, we are seeing lower occupancy rates in NHs. Older adults without financial resources, disproportionality minority older adults, are becoming an increasing proportion of NH residents, as they may not be able to as readily access these care alternatives. Current and future policies should focus on expanding equitable access to the remaining long-term care services and supports in the continuum of care, particularly given the policies and initiatives focused on decreasing NH utilization through support of home and community based alternatives.[49] Although NHs continue to focus more on short-stay post-acute care residents and long-stay residents with dementia, more work will need to be done in community-based settings to ensure the highest quality care and life. Improving quality is also about improving equity, and it is important for future work to examine access to quality care for our most vulnerable older adults who are sometimes triply and doubly vulnerable because of their cognitive status, race, and/or socioeconomic position. As our work shows, much of the quality progress made in NHs has been because of regulation and oversight over the years. The same level of oversight does not exist for all community alternatives, but the evidence presented here is indicative of effective practices.

Future research is also needed to understand whether these improvements in quality over the past 30 years have been equitable on the basis of race, socioeconomic status, gender, and geography. In sum, our findings document the 30-year history of NHs since the passage of the seminal legislation: OBRA 1987. As we look toward the future of long-term care, it is important that we reflect on the past.

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Hospital Transfer Rates Among US Nursing Home Residents With Advanced Illness Before and After Initiatives to Reduce Hospitalizations

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IMPORTANCE Hospital transfers among nursing home residents in the United States who have been diagnosed with advanced illnesses and have limited life expectancy are often burdensome, costly, and of little clinical benefit. National initiatives, introduced since 2012, have focused on reducing such hospitalizations, but little is known about the consequences of these initiatives in this population.

OBJECTIVE To investigate the change in hospital transfer rates among nursing home residents with advanced illnesses, such as dementia, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD), from 2011 to 2017—before and after the introduction of national initiatives to reduce hospitalizations.

DESIGN, SETTING, AND PARTICIPANTS In this cross-sectional study, nationwide Minimum Data Set (MDS) assessments from January 1, 2011, to December 31, 2016 (with the follow-up for transfer rates until December 31, 2017), were used to identify annual inception cohorts of long-stay (>100 days) nursing home residents who had recently progressed to the advanced stages of dementia, CHF, or COPD. The data were analyzed from October 24, 2018, to October 3, 2019.

MAIN OUTCOMES AND MEASURES The number of hospital transfers (hospitalizations, observation stays, and emergency department visits) per person-year alive was calculated from the MDS assessment from the date when residents first met the criteria for advanced illness up to 12 months afterward using Medicare claims from 2011 to 2017. Transfer rates for all causes, potentially avoidable conditions (sepsis, pneumonia, dehydration, urinary tract infections, CHF, and COPD), and serious bone fractures (pelvis, hip, wrist, ankle, and long bones of arms or legs) were investigated. Hospice enrollment and mortality were also ascertained.

RESULTS The proportions of residents in the 2011 and 2016 cohorts who underwent any hospital transfer were 56.1% and 45.4% of those with advanced dementia, 77.6% and 69.5% of those with CHF, and 76.2% and 67.2% of those with COPD. The mean (SD) number of transfers per person-year alive for potentially avoidable conditions was higher in the 2011 cohort vs 2016 cohort: advanced dementia, 2.4 (14.0) vs 1.6 (11.2) (adjusted risk ratio [aRR], 0.73; 95% CI, 0.65-0.81); CHF, 8.5 (32.0) vs 6.7 (26.8) (aRR, 0.72; 95% CI, 0.65-0.81); and COPD, 7.8 (30.9) vs 5.5 (24.8) (aRR, 0.64; 95% CI, 0.57-0.72). Transfers for bone fractures remained unchanged, and mortality did not increase. Hospice enrollment was low across all illness groups and years (range, 23%-30%).

CONCLUSIONS AND RELEVANCE The findings of this study suggest that concurrent with new initiatives aimed at reducing hospitalizations, hospital transfers declined between 2011 and 2017 among nursing home residents with advanced illnesses without increased mortality rates. Opportunities remain to further reduce unnecessary hospital transfers in this population and improve goal-directed care for those residents who opt to forgo hospitalization.

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Supplemental content

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A central objective of the Patient Protection and Affordable Care Act (ACA) of 2010 was to transform health care by ensuring that patients receive high-value, effective care.[1] Toward this objective, there has been particular focus on reducing potentially avoidable hospital transfers from the long-term care setting. The opportunity and need to reduce avoidable hospitalizations are greatest among people with advanced chronic illnesses[2] for whom the burdens of hospitalization often outweigh the benefits.[3-5] Little is currently known about how hospital transfer rates have changed among this population since broad initiatives were introduced.

Approximately 50% of nursing home residents experience 1 or more hospitalization in their last year of life.[6] At least half of these hospitalizations are estimated to be potentially avoidable because the acute condition could be managed effectively in the nursing home or the hospital-level care is not aligned with patient preferences.[7-11] Decisions regarding hospital transfers should be guided by the primary goal of care (eg, prolongation of life vs comfort), which is comfort for most nursing home residents with advanced illness.[12-15] With rare exceptions (eg, serious bone fractures), hospitalization seldom promotes the goal of comfort.

Since 2012, several new approaches have emerged from the ACA to try to reduce hospital transfers of nursing home residents. Care models that enhance the nursing home's on-site capability to manage specific targeted conditions (sepsis, pneumonia, urinary tract infections, dehydration, congestive heart failure [CHF], and chronic obstructive pulmonary disease [COPD]) have shown promise through the quality initiative program of the Centers for Medicare & Medicaid Services (CMS) to reduce avoidable hospitalizations.[9,10] Evaluation of the initiative's first phase in 7 states demonstrated estimated net reductions in 2015 of 2.2% to 9.3% in the probability of an all-cause hospitalization and 1.4% to 7.2% in the probability of a potentially avoidable hospitalization for participating residents compared with comparison groups.[1] Alternative payment models, such as accountable care organizations and bundled payments, also create financial incentives for nursing homes to reduce hospital transfers.[16] The Hospital Readmissions Reduction Program (HRRP) implemented financial penalties for hospitals with excess readmissions for target conditions including pneumonia, CHF, and COPD.[17,18] These concurrent initiatives raised national awareness and forged collaborations around transitional care to avoid unnecessary hospitalizations.[19] The consequences of such initiatives on hospital transfer rates, specifically among residents with advanced illnesses, have not been reported, to our knowledge.

The present study used Minimum Data Set (MDS) assessments linked to Medicare data to examine the national trends of hospital transfer rates from 2011 to 2017 among long-stay, fee-for-service nursing home residents with advanced dementia, CHF, or COPD. We specifically examined transfers for conditions that were deemed to be potentially avoidable and were the target of recent policy initiatives. For comparison, we also examined hospital transfer rates for serious bone fractures, which we hypothesized would be less affected by such initiatives. Finally, we assessed mortality and hospice enrollment rates.

Key Points

Question How did the hospital transfer rates change between 2011 and 2017 among nursing home residents diagnosed with advanced illness and limited life expectancy before and after the introduction of national initiatives to reduce hospitalizations?

Findings In this US nationwide cross-sectional study of 6 cohorts of nursing home residents with advanced illness, such as dementia, congestive heart failure, and chronic obstructive pulmonary disease, although hospital transfers for all causes and for potentially avoidable conditions were common, such transfers were found to have declined considerably from 2011 to 2017, and concurrent hospice use was low across all cohorts.

Meaning The findings of this study suggest that hospital transfer rates among nursing home residents with advanced illness declined from 2011 to 2017 and that opportunities remain to reduce unnecessary hospital transfers among residents with advanced illness.

Methods

Advanced Illness Cohorts

In this cross-sectional study, the MDS version 3.0 assessments[20] from federally licensed nursing homes in the United States were used from January 1, 2011, to December 31, 2016, to construct annual inception cohorts of long-stay residents (ie, >100 days) aged 65 years or older who were diagnosed with advanced dementia, CHF, or COPD. The MDS version 3.0 is a standardized, comprehensive assessment conducted on all nursing home residents at admission and at routine intervals (eg, quarterly) and was implemented in 2011.[20] Key differences between MDS 3.0 and MDS 2.0 precluded us from using MDS before 2011.[21] To construct these cohorts, we identified residents from the first MDS assessment at which they met the full criteria for advanced dementia, CHF, or COPD (hereafter, baseline assessment) in each calendar year. Residents may have had the illness, such as CHF, on a prior MDS assessment but were not included in the cohort until they first met the criteria for advanced disease, as described below. Residents had to be continuously enrolled in the Medicare Parts A and B fee-for-service program for up to 12 months after their baseline assessment and could belong to more than 1 advanced illness group. Residents enrolled in hospice at the baseline assessment were excluded. The institutional review board at Brown University approved this study under expedited review and waived informed consent under 45 CFR 46.116.

We defined advanced dementia, CHF, and COPD using criteria adapted from previous studies[5,22,23] using MDS to approximate hospice eligibility criteria, thus implying limited life expectancy. Advanced dementia criteria included the following: diagnosis of Alzheimer disease or other dementia, advanced cognitive impairment as defined by a score of 3 (moderate impairment) or 4 (severe impairment) on the Cognitive Function Scale,[24] and extensive or total assistance needed for eating and transferring. Advanced CHF was defined as follows: CHF diagnosis, shortness of breath while sitting or supine, and extensive or total assistance needed for transferring. Advanced COPD was

defined as follows: diagnosis of COPD (including emphysema and asthma), shortness of breath while sitting or supine, and extensive or total assistance needed for transferring.

Covariates

Age, sex, nonwhite race, dual-eligible status indicating beneficiaries qualifying for both Medicare and Medicaid, MDS 3.0 mortality risk score (MRS3),[25] and cohort year were ascertained from the baseline MDS assessment. The MRS3 (0-39) is a validated risk score based on demographic, clinical, and functional characteristics, with higher values indicating greater 30- and 60-day mortality risk. An MRS3 score of 8 or higher is associated with a 5.4 times increased odds of 30-day mortality compared with scores lower than 8.[25]

Outcomes

Residents were followed for up to 12 months from their baseline MDS assessment using Medicare claims from January 1, 2011, to December 31, 2017, to ascertain the occurrence of hospital transfers for all causes, potentially avoidable conditions, and serious bone fractures. Thus, person-time and outcomes spanned 2 calendar years (eg, for the 2016 cohort, outcomes were assessed in both 2016 and 2017). Hospital transfers included acute hospitalizations, observation stays, and emergency department (ED) visits. Hospitalizations were identified from the Medicare Provider Analysis and Review file.[26] Observation stays were defined as any outpatient facility claim for observation services using Healthcare Common Procedure Codes G0378-G0379,[27] *Current Procedural Terminology* codes 99217-99220,[28] or hospital outpatient revenue center code 0762. Emergency department visits were ascertained using outpatient facility claims with revenue center codes 0450-0459 or 0981, Healthcare Common Procedure Codes G0380-G0385, or carrier claims for ED services using *Current Procedural Terminology* codes 99281-99285. Observation stays that became admissions were considered to be hospitalizations. Emergency department visits that became hospitalizations or observation stays were classified accordingly.

Potentially avoidable transfers were identified using ambulatory care-sensitive conditions,[7-11] including sepsis, pneumonia, dehydration, urinary tract infections, heart failure, and COPD (including emphysema and asthma) (eTable 1 in the Supplement). These conditions account for 78% of the potentially avoidable hospitalizations among nursing home residents.[9] Serious bone fractures were examined as counterfactual conditions that usually result in hospital transfers regardless of existing policies and included fractures of the pelvis, hip, long bones of arms (humerus, ulna, and radius) and legs (femur, tibia, and fibula), wrists, and ankles (eTable 1 in the Supplement). We classified hospital transfers for these conditions using the claim's principal diagnosis. Mortality and hospice enrollment within 12 months after the baseline assessment were identified from the Medicare Master Beneficiary Summary File[29] and the 2011 to 2017 hospice claims, respectively.

Statistical Analysis

The data were analyzed from October 24, 2018, to October 3, 2019. Descriptive analyses were performed for resident characteristics and outcomes using means with SDs for continuous variables and proportions for categorical variables. Descriptive results were generated for each advanced illness group stratified by cohort year. Hospital transfers were further described by type (hospitalizations, observation stays, and ED visits) and by condition (all causes, potentially avoidable, and serious bone fractures). The proportion of potentially avoidable transfers attributable to specific diagnoses (eg, sepsis, pneumonia) were also calculated and presented graphically. Outliers defined as residents with all-cause hospital transfer rates exceeding 365 transfers per person-year alive across 12 months were removed (<1% of residents across all cohorts combined). Hospital transfer outcomes across 12 months were measured as the proportion of residents who experienced at least 1 transfer and the number of transfers per person-year alive. Mortality and hospice enrollment outcomes across 12 months were measured as the proportion of residents who experienced the event and the time to event. For all models, the main independent variable was the cohort year, with 2011 as the referent category. All models were adjusted for age, sex, nonwhite race, and MRS3 score. All models were fitted using generalized estimating equations to account for clustering within nursing homes and included an offset for log-transformed person-time.

Binary outcomes (any hospital transfers, hospice enrollment, and mortality) were analyzed using log-linked binomial models to estimate relative risk with cohort year. Zero-inflated Poisson regression models were used to analyze outcomes measured as number of transfers per person-year alive to allow for overdispersion owing to the high proportion of residents without a hospital transfer.[30] Adjusted risk ratios (aRRs) and 95% CIs were generated for these analyses. Finally, Cox proportional hazards regression models were used to analyze time-to-event outcomes (hospice enrollment, mortality) across 12 months of follow-up. In the hospice model, death without hospice was considered to be a competing risk. Adjusted hazard ratios and 95% CIs were estimated from these analyses. Analyses were performed using SAS, version 9.4 (SAS Institute Inc).

Results

Table 1 gives the characteristics of the nursing home residents by cohort year and advanced illness group. The 2011 cohort sizes were smaller for all illness groups compared with those of other years because residents had to be in the nursing home for at least 100 days and MDS data before 2011 were not used. Nonetheless, the overall distributions of age and sex were similar across cohort years within illness groups. Residents with advanced CHF (10.1-10.9) and COPD (9.0-9.6) generally had higher MRS3 scores (higher mortality risk) compared with residents with advanced dementia (7.5-8.4). All cohorts were predominately female, white, and dually eligible for Medicare and Medicaid.

Table 2 provides hospital transfer outcomes. All-cause hospital transfers were common in all illness groups across all years and were consistently lower for residents with advanced dementia compared with other groups. The most pronounced reduction in transfers occurred from the 2011 to 2012 cohort and

Table 1. Characteristics of Nursing Home Residents With Advanced Illness by Cohort Year[a]

Characteristic	Cohort Year[a]					
	2011[b]	2012	2013	2014	2015	2016
Advanced Dementia						
Residents, No.	18 178[b]	44 385	50 725	53 078	53 418	52 221
Follow-up, mean (SD), d	232.5 (146.0)	238.2 (143.6)	242.8 (143.0)	241.8 (142.4)	243.6 (142.7)	238.7 (143.5)
Age, mean (SD), y	85.0 (7.6)	85.4 (7.6)	85.6 (7.8)	85.8 (7.8)	85.9 (7.9)	85.8 (8.0)
Female, No. (%)	12 400 (68.2)	30 760 (69.3)	35 630 (70.2)	37 303 (70.3)	37 906 (71.0)	36 572 (70.0)
Nonwhite race, No. (%)	3196 (17.6)	7312 (16.5)	8140 (16.0)	8508 (16.0)	8467 (15.9)	8464 (16.2)
Dual eligible, No. (%)[c]	12 654 (69.6)	32 238 (72.6)	37 522 (74.0)	39 462 (74.3)	39 558 (74.1)	39 280 (75.2)
MRS3, mean (SD)[d]	8.4 (3.6)	8.1 (3.6)	7.9 (3.5)	7.7 (3.4)	7.6 (3.4)	7.5 (3.3)
Advanced Congestive Heart Failure						
Residents, No.	8866[b]	16 667	17 782	17 392	17 562	18 931
Follow-up, mean (SD), d alive	207.8 (149.3)	217.8 (148.1)	228.5 (146.7)	226.1 (146.1)	223.9 (148.0)	218.9 (149.5)
Age, mean (SD), y	84.2 (8.1)	84.5 (8.2)	84.5 (8.3)	84.5 (8.5)	84.5 (8.6)	84.3 (8.6)
Female, No. (%)	5994 (67.6)	11 484 (68.9)	12 247 (68.9)	11 999 (69.0)	12 183 (69.4)	12 865 (68.0)
Nonwhite race, No. (%)	1417 (16.0)	2429 (14.6)	2544 (14.3)	2454 (14.1)	2338 (13.3)	2812 (14.9)
Dual eligible, No. (%)[c]	6447 (73.1)	12 665 (76.0)	13 437 (75.6)	13 216 (76.0)	13 097 (74.6)	14 224 (75.1)
MRS3, mean (SD)[d]	10.7 (3.3)	10.9 (3.1)	10.8 (3.0)	10.5 (3.0)	10.7 (3.0)	10.1 (2.9)
Advanced Chronic Obstructive Pulmonary Disease						
Residents, No.	8467[b]	16 597	17 806	17 166	17 409	19 154
Follow-up, mean (SD), d alive	220.5 (148.3)	233.8 (144.8)	243.7 (143.3)	241.9 (142.7)	242.1 (143.9)	239.5 (144.8)
Age, mean (SD), y	82.8 (8.2)	83.1 (8.2)	83.1 (8.4)	83.2 (8.6)	83.1 (8.5)	83.1 (8.6)
Female, No. (%)	5584 (64.6)	10 818 (65.2)	11 788 (66.2)	11 303 (65.8)	11 573 (66.5)	12 668 (66.1)
Nonwhite race, No. (%)	1386 (16.0)	2422 (14.6)	2523 (14.2)	2441 (14.2)	2310 (13.3)	2775 (14.5)
Dual eligible, No. (%)[c]	6566 (75.9)	12 933 (77.9)	14 019 (78.7)	13 499 (78.6)	13 414 (77.1)	15 121 (78.9)
MRS3, mean (SD)[d]	9.6 (3.3)	9.6 (3.2)	9.6 (3.0)	9.4 (3.0)	9.3 (2.9)	9.0 (3.0)

Abbreviations: MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using MDS 3.0 assessments from 2011 to 2016.

[b] Cohort sizes from 2011 were smaller compared with those of other years because residents had to be in the nursing home for at least 100 days and MDS data before 2011 were not used.

[c] Beneficiaries who qualify for both Medicare and Medicaid benefits.

[d] MDS 3.0 mortality risk score, range 0-39; higher scores indicate higher risk of mortality.

then from the 2012 to 2013 cohort. Data showed no further reduction after 2013 and higher rates in 2016 than in 2015, particularly in the CHF and COPD cohorts. The adjusted proportions of residents who had at least 1 hospital transfer for any cause in the 2011 and 2016 cohorts were 56.1% and 45.4% for those with advanced dementia, 77.6% and 69.5% for those with CHF, and 76.2% and 67.2% for those with COPD. The mean (SD) number of hospital transfers per person-year alive for any cause was higher in the 2011 vs 2016 cohorts for nursing home residents with advanced dementia, 5.8 (22.7) vs 3.9 (17.9); CHF, 16.8 (43.9) vs 13.5 (38.9); and COPD, 15.6 (42.4) vs 11.2 (35.8). For each illness, the decrease in transfer rates between the 2011 and 2016 cohorts remained significant (advanced dementia [aRR, 0.72; 95% CI, 0.67-0.78]; CHF [aRR, 0.74; 95% CI, 0.68-0.80]; and COPD [aRR, 0.66; 95% CI, 0.61-0.72]) after adjustment for baseline characteristics. As demonstrated in **Figure 1**, reductions in hospital transfer rates over time were almost entirely attributable to declines in acute hospitalizations in each illness group.

Transfers for potentially avoidable conditions were common and decreased over time in each illness group in patterns similar to those of transfers for all causes (Table 2). The adjusted proportions of residents having at least 1 hospital transfer for a potentially avoidable condition in the 2011 and 2016 cohorts, respectively, were 26.5% and 20.4% for those with advanced dementia; 50.0% and 42.9% for those with CHF; and 49.2% and 40.7% for those with COPD. The mean (SD) number of hospital transfers per person-year alive for potentially avoidable conditions for the 2011 vs 2016 cohorts were 2.4 (14.0) vs 1.6 (11.2) (aRR, 0.73; 95% CI, 0.65-0.81) for those with advanced dementia; 8.5 (32.0) vs 6.7 (26.8) (aRR, 0.72; 95% CI, 0.65-0.81) for those with CHF; and 7.8 (30.9) vs 5.5 (24.8) (aRR, 0.64; 95% CI, 0.57-0.72) for those with COPD. Sepsis was the most frequent condition attributed to potentially avoidable transfers in all cohort years for all groups (**Figure 2**). The next most frequent conditions documented for potentially avoidable transfers were pneumonia and urinary tract infections for advanced dementia and CHF and pneumonia for both advanced CHF and COPD.

Hospital transfers for a primary diagnosis of serious bone fractures were relatively uncommon and, as hypothesized, remained unchanged for all advanced illness groups across all years (Table 2). **Table 3** gives the mortality and hospice enrollment outcomes. Hospice enrollment was low across all illness groups and years (range, 23%-30%). Mortality within 1 year exceeded 50% for all advanced illness groups across all years but did not increase over time in any illness group. Hospice use

Table 2. Hospital Transfer Outcomes Across 12 Months Among Nursing Home Residents With Advanced Illness by Cohort Year[a]

Outcome	Cohort Year[a] 2011	2012	2013	2014	2015	2016
Advanced Dementia						
Any transfer, adjusted % (95% CI)[b]						
All causes	56.1 (55.4-56.9)	51.1 (50.5-51.4)	45.9 (45.6-46.4)	45.1 (44.7-45.5)	44.5 (44.1-44.9)	45.4 (44.9-45.8)
Potentially avoidable[c]	26.5 (25.9-27.2)	23.2 (22.8-23.6)	20.0 (19.6-20.3)	19.7 (19.4-20.1)	19.5 (19.2-19.8)	20.4 (20.1-20.7)
Fractures[d]	2.4 (2.2-2.6)	2.3 (2.2-2.5)	2.3 (2.1-2.4)	2.3 (2.2-2.5)	2.4 (2.2-2.5)	2.4 (2.3-2.6)
Hospital transfers per person-year alive						
All causes, mean (SD)	5.8 (22.7)	4.1 (16.7)	3.3 (14.4)	3.1 (13.6)	3.2 (14.2)	3.9 (17.9)
Adjusted RR[b]	1 [Reference]	0.71 (0.66-0.77)	0.58 (0.54-0.62)	0.56 (0.52-0.60)	0.57 (0.53-0.62)	0.72 (0.67-0.78)
Potentially avoidable, mean (SD)[c]	2.4 (14.0)	1.6 (10.2)	1.2 (7.8)	1.2 (7.6)	1.2 (8.0)	1.6 (11.2)
Adjusted RR[b]	1 [Reference]	0.67 (0.60-0.75)	0.52 (0.47-0.58)	0.51 (0.46-0.57)	0.53 (0.48-0.59)	0.73 (0.65-0.81)
Fractures, mean (SD)[d]	0.06 (0.78)	0.06 (0.87)	0.05 (0.82)	0.06 (0.72)	0.07 (1.08)	0.08 (1.24)
Adjusted RR	1 [Reference]	0.98 (0.77-1.24)	0.85 (0.67-1.07)	0.93 (0.75-1.16)	1.03 (0.81-1.30)	1.28 (1.00-1.61)
Advanced Congestive Heart Failure						
Any transfer, adjusted % (95% CI)[b]						
All causes	77.6 (76.7-78.5)	69.3 (68.6-70.0)	63.6 (62.9-64.3)	63.2 (62.5-63.9)	64.7 (63.9-65.4)	69.5 (68.9-70.2)
Potentially avoidable[c]	50.0 (49.9-51.1)	41.5 (40.7-42.2)	36.4 (35.7-37.1)	36.6 (35.8-37.3)	38.1 (37.3-38.8)	42.9 (42.2-43.6)
Fractures[d]	2.0 (1.8-2.3)	1.9 (1.8-2.2)	2.0 (1.8-2.2)	2.1 (1.9-2.3)	2.0 (1.8-2.2)	2.0 (1.8-2.2)
Hospital transfers per person-year alive						
All causes, mean (SD)	16.8 (43.9)	11.1 (33.6)	8.0 (24.1)	8.0 (24.3)	9.6 (28.3)	13.5 (38.9)
Adjusted RR[b]	1 [Reference]	0.69 (0.64-0.75)	0.49 (0.45-0.53)	0.49 (0.45-0.53)	0.57 (0.53-0.62)	0.74 (0.68-0.80)
Potentially avoidable, mean (SD)[c]	8.5 (32.0)	5.2 (23.5)	3.5 (15.8)	3.4 (15.1)	4.5 (19.6)	6.7 (26.8)
Adjusted RR[b]	1 [Reference]	0.64 (0.58-0.72)	0.42 (0.38-0.47)	0.42 (0.38-0.47)	0.53 (0.48-0.59)	0.72 (0.65-0.81)
Fractures, mean (SD)[d]	0.08 (1.20)	0.08 (1.59)	0.08 (1.01)	0.07 (1.01)	0.07 (1.21)	0.90 (2.37)
Adjusted RR	1 [Reference]	0.99 (0.65-1.51)	0.86 (0.60-1.24)	0.84 (0.58-1.21)	0.82 (0.55-1.21)	1.02 (0.63-1.63)
Advanced Chronic Obstructive Pulmonary Disease						
Any transfer, adjusted % (95% CI)[b]						
All causes	76.2 (75.3-77.1)	69.1 (68.4-69.9)	63.3 (62.6-64.0)	63.1 (62.3-63.8)	63.9 (63.2-64.7)	67.2 (66.6-67.9)
Potentially avoidable[c]	49.2 (48.2-50.2)	41.2 (40.4-41.9)	35.9 (35.2-36.6)	36.0 (35.3-36.7)	37.2 (36.4-37.9)	40.7 (40.0-41.4)
Fractures[d]	2.3 (2.0-2.6)	2.2 (2.0-2.5)	2.3 (2.1-2.6)	2.4 (2.2-2.6)	2.2 (2.0-2.5)	2.2 (2.0-2.5)
Hospital transfers per person-year alive						
All causes, mean (SD)	15.6 (42.4)	9.9 (30.2)	7.3 (22.1)	7.7 (24.8)	8.6 (27.4)	11.2 (35.8)
Adjusted RR[b]	1 [Reference]	0.60 (0.55-0.65)	0.43 (0.39-0.46)	0.46 (0.41-0.49)	0.50 (0.46-0.55)	0.66 (0.61-0.72)
Potentially avoidable, mean (SD)[c]	7.8 (30.9)	4.6 (21.1)	3.1 (14.3)	3.2 (15.5)	3.8 (17.5)	5.5 (24.8)
Adjusted RR[b]	1 [Reference]	0.55 (0.49-0.62)	0.36 (0.32-0.41)	0.37 (0.33-0.42)	0.44 (0.39-0.49)	0.64 (0.57-0.72)
Fractures, mean (SD)[d]	0.09 (1.19)	0.07 (0.98)	0.08 (0.98)	0.09 (1.08)	0.07 (0.74)	0.95 (2.16)
Adjusted RR	1 [Reference]	0.79 (0.55-1.11)	0.82 (0.58-1.14)	0.88 (0.63-1.23)	0.69 (0.50-0.96)	.095 (0.63-1.46)

Abbreviations: COPD, chronic obstructive pulmonary disease; MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score; RR, relative risk.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using MDS assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify transfers occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and transfers were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, transfers were assessed in both 2016 and 2017).

[b] All models were adjusted for age, sex, nonwhite race, and MRS3 and included an offset for log(person-time).

[c] Transfers for primary diagnosis of sepsis, pneumonia, dehydration, urinary tract infections, heart failure, and COPD or asthma.

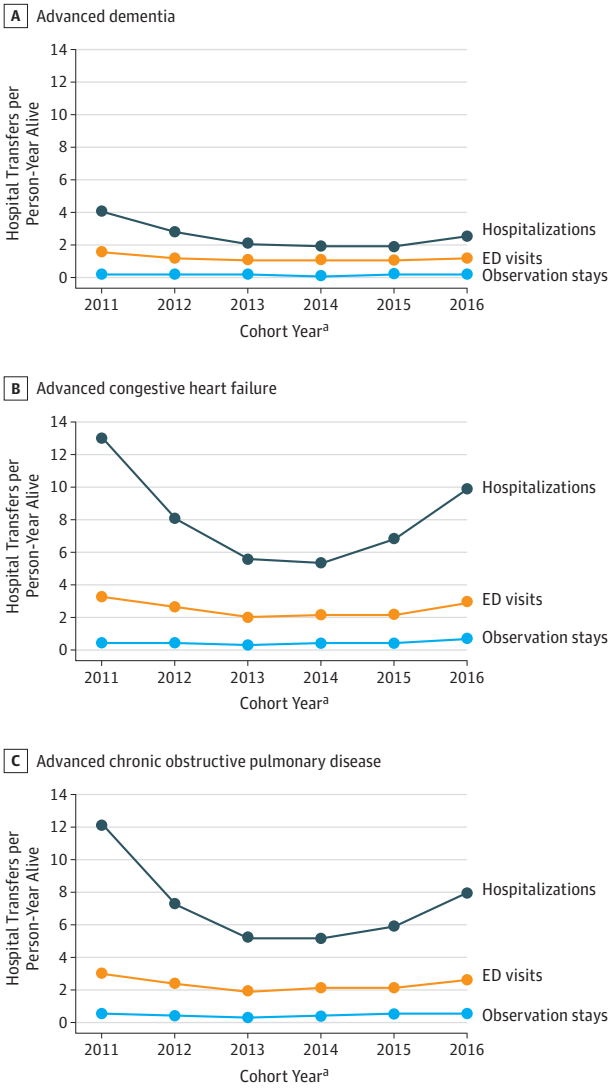
[d] Fractures of pelvis, hip, wrist, ankle, and long bone fractures of arms (humerus, ulna, and radius) and legs (femur, tibia, and fibula).

was low for all illnesses across all years but increased slightly for the 2016 cohort of residents with advanced dementia.

Discussion

We examined changes in national hospital transfer rates among long-stay nursing home residents with advanced dementia, CHF, and COPD from 2011 to 2017, a period during which national initiatives were introduced to reduce hospital transfers across care settings, including the long-term care setting. Transfers for all causes and potentially avoidable conditions declined for each advanced illness group during these years without adversely affecting mortality. This decline was almost entirely attributable to a reduction in hospitalizations rather than in observation stays or ED visits. In contrast, transfer rates for serious bone fractures, which are less likely to be associated with policy changes, remained stable. Sepsis and pneumonia were common reasons for potentially avoidable hospital transfers across all groups. Although the hospital transfer rates for all causes and potentially avoidable conditions declined, they remained common. In the 2016 cohorts, 45% of the residents with advanced

Figure 1. Transfer Rates for Hospitalizations, Emergency Department (ED) Visits, and Observation Stays for Illness Groups by Cohort Year



[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using Minimum Data Set assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify transfers occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and transfers were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, transfers were assessed in both 2016 and 2017).

dementia and roughly two-thirds of those with advanced CHF and COPD experienced at least 1 transfer despite the greater than 50% mortality rate across all groups. These observations, coupled with low hospice enrollment throughout all years, suggest that opportunities remain to further reduce hospital transfers and improve end-of-life care for nursing home residents with advanced illnesses.

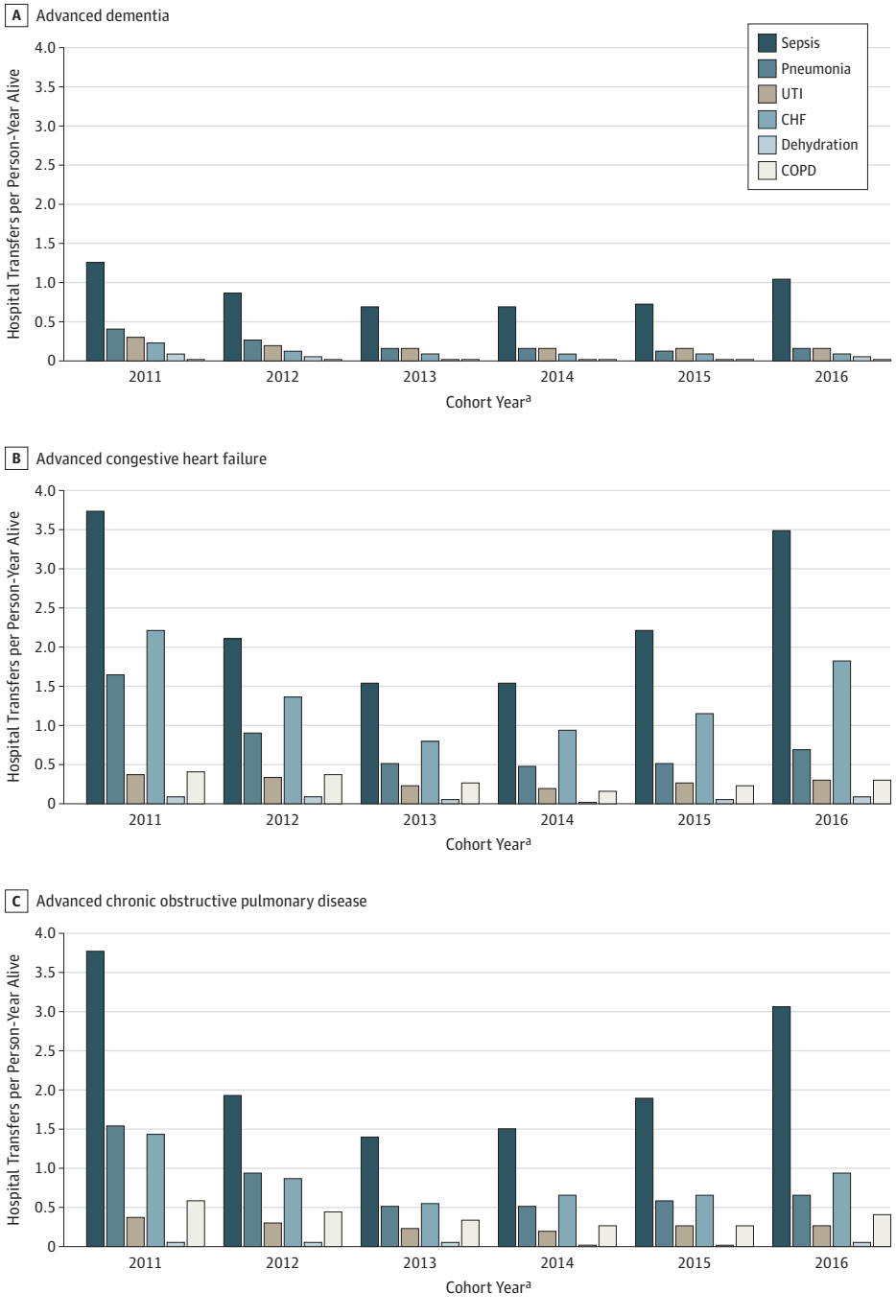
Although several studies describe changes in hospitalization rates in the United States in 2014 and 2015,[17,18,31-33] the present study focused on long-term care residents with advanced illness. The issue is particularly pertinent for this population because hospital transfers can be especially burdensome, of little clinical benefit, and distressing for family members.[3-5,34] Treatment decisions should be guided by patient preferences. Thus, if the decline in transfer rates observed in this study reflect, in part, decisions to avoid hospitalizations in favor of comfort-focused care, then such care should be available in the nursing home. High-quality palliative care is currently lacking in many US nursing homes.[35-37] Palliative care and hospice improve the quality of end-of-life care among nursing home residents, including reducing hospitalization rates.[32,36-39] Although we could not ascertain whether residents received palliative care outside the Medicare Hospice Benefit, we observed low rates of hospice enrollment and no concurrent uptake of hospice as hospital transfer rates declined. Given the increased scrutiny and federal audits of nursing homes with long hospice stays, the present study suggests that most residents with advanced dementia, CHF, and COPD are not receiving hospice care near the end of life.

Potentially avoidable hospital transfers among dual-eligible beneficiaries are key quality measures in long-term care and cost Medicare an estimated $2.6 billion annually.[9,40] Infections accounted for most potentially avoidable hospital transfers across advanced illness groups. Among residents with advanced CHF and COPD, exacerbations of these underlying conditions were also common reasons for transfers. Consequently, advance care planning among providers, residents, and family members presents a critical opportunity for informed decision-making about wishes for future hospitalizations in anticipation of expected clinical complications, and online resources are available to help guide these discussions.[41] Proxies of residents with advanced dementia should understand that recurrent infections are a hallmark of the end stage of the disease. Among residents with advanced illness for whom curative care remains aligned with their preferences, infections and cardiopulmonary decompensations can often be managed in the nursing home.[3,42-45] Of note, mortality did not increase across the cohort years in any group despite the decline in hospital transfers.

Programmatic initiatives, such as Interventions to Reduce Acute Care Transfers (INTERACT),[46] have been adopted widely to avoid unnecessary hospitalizations by improving the nursing home's capacity to provide on-site evaluation and management of acute changes through early recognition, monitoring, and staff training. Although a recent cluster randomized clinical trial of INTERACT demonstrated no effect on hospitalizations or ED visits, the trial highlighted the complexities of implementing and sustaining such interventions in nursing homes.[16]

This study's findings are consistent with those of studies documenting prominent declines in hospitalization and readmission rates between 2010 and 2012 after the enactment of the ACA and announcement of the HRRP, a Medicare value-based purchasing program that financially penalizes hospitals with excess readmissions for specific conditions.[17,18,47-49] Health care systems may have made systemic preparations in anticipation of the HRRP penalty phase in October 2012. Our findings also support the possible spillover effect of HRRP onto nonspecific conditions.[17,18,47,48,50] Consistent with other studies, we

Figure 2. Hospital Transfer Rates for Potentially Avoidable Conditions by Cohort Year



CHF indicates congestive heart failure; COPD, chronic obstructive pulmonary disease; and UTI, urinary tract infection.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using Minimum Data Set assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify transfers occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and transfers were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, transfers were assessed in both 2016 and 2017).

observed a leveling off of hospital transfer rates during 2014 to 2016.[17,18,47,48] Chhabra and colleagues[48] suggest that this pattern may reflect a floor effect—a point at which achieving additional reductions in rates becomes more difficult. Regression to the mean may also partly explain the marked decline observed in transfer rates compared with those in 2011.[33]

Several factors acting in parallel may contribute to the observed declines in potentially avoidable transfers. Increased attention and quality and performance improvement initiatives have targeted unnecessary hospital transfers. Recent studies demonstrate reductions in hospital readmissions for potentially avoidable conditions after implementation of the HRRP.[17,18] Although nursing homes were not subject to financial penalties under HRRP, many nursing homes across the United States adopted quality improvement programs, such as INTERACT, in anticipation of CMS quality assurance and performance improvement regulations.[46] In addition, nursing homes included in accountable care organizations or other preferred referral

Table 3. Mortality and Hospice Enrollment Across 12 Months Among Nursing Home Residents With Advanced Illness by Cohort Year[a]

Outcome	Cohort Year[a] 2011	2012	2013	2014	2015	2016
Advanced Dementia						
12-mo Mortality adjusted						
% (95% CI)[b]	52.8 (51.6-53.1)	51.8 (51.3-52.3)	50.5 (50.1-51.0)	52.0 (51.6-52.5)	51.0 (50.5-51.4)	53.3 (52.8-53.7)
HR (95% CI)[c]	1 [Reference]	0.97 (0.95-1.00)	0.94 (0.92-0.96)	0.98 (0.95-1.00)	0.95 (0.93-0.98)	1.02 (0.99-1.04)
Hospice in 12 mo adjusted						
% (95% CI)[b]	27.2 (26.5-27.8)	26.9 (26.5-27.4)	27.1 (26.7-27.4)	27.2 (26.9-27.6)	27.9 (27.6-28.3)	30.0 (29.6-30.4)
HR (95% CI)[d]	1 [Reference]	0.97 (0.94-1.01)	0.97 (0.94-1.00)	0.98 (0.95-1.02)	1.01 (0.98-1.04)	1.11 (1.08-1.15)
Advanced CHF						
12-mo Mortality adjusted						
% (95% CI)[b]	61.6 (60.6-62.6)	58.9 (58.1-59.6)	55.4 (54.7-56.2)	56.8 (56.0-57.5)	56.3 (55.5-57.0)	57.3 (56.6-58.0)
HR (95% CI)[c]	1 [Reference]	0.94 (0.90-0.99)	0.87 (0.83-0.91)	0.87 (0.84-0.90)	0.87 (0.84-0.90)	0.89 (0.86-0.92)
Hospice in 12 mo adjusted						
% (95% CI)[b]	27.9 (27.0-28.9)	27.1 (26.4-27.8)	25.8 (25.2-26.5)	26.9 (26.2-27.5)	27.4 (26.7-28.0)	29.9 (29.2-30.5)
HR (95% CI)[d]	1 [Reference]	0.94 (0.89-0.99)	0.87 (0.83-0.91)	0.91 (0.87-0.95)	0.93 (0.89-0.98)	1.03 (0.98-1.08)
Advanced COPD						
12-mo Mortality adjusted						
% (95% CI)[b]	57.8 (56.7-58.9)	53.6 (52.8-54.3)	49.9 (49.0-50.5)	51.3 (50.6-52.1)	50.7 (50.0-51.5)	52.2 (51.4-52.9)
HR (95% CI)[c]	1 [Reference]	0.88 (0.85-0.91)	0.80 (0.77-0.82)	0.82 (0.79-0.85)	0.82 (0.79-0.85)	0.85 (0.82-0.88)
Hospice in 12 mo adjusted						
% (95% CI)[b]	24.7 (23.8-25.6)	23.9 (23.2-24.6)	23.1 (22.5-24.0)	23.3 (22.7-24.0)	24.1 (23.4-24.7)	26.2 (25.6-26.9)
HR (95% CI)[d]	1 [Reference]	0.92 (0.87-0.97)	0.87 (0.82-0.91)	0.87 (0.83-0.92)	0.91 (0.86-0.95)	1.00 (0.95-1.05)

Abbreviations: CHF, congestive heart failure; COPD, chronic obstructive pulmonary disease; HR, hazard ratio; MDS, Minimum Data Set; MRS3, MDS 3.0 mortality risk score.

[a] Cohort year refers to the calendar year of the inception cohort constructed for each advanced illness using MDS assessments from 2011 to 2016. Medicare data from 2011 to 2017 were used to identify outcomes occurring within 12 months of meeting the criteria for advanced illness for each cohort. Thus, person-time and outcomes were assessed for up to 12 months and spanned 2 calendar years (eg, for the 2016 cohort, outcomes were assessed in both 2016 and 2017).

[b] Adjusted for age, sex, nonwhite race, and MRS3 and offset for person-time.

[c] Adjusted for age, sex, nonwhite race, and MRS3. Mortality: HR <1.00 indicates lower rate of death relative to rate in 2011.

[d] Adjusted for age, sex, nonwhite race, and MRS3. Death was considered a competing risk. Hospice: HR <1.00 indicates lower rate of hospice enrollment relative to rate in 2011.

networks were further incentivized to reduce hospitalizations to remain in network.[16] The CMS is conducting demonstration projects to examine payment models that include value-based purchasing incentives as part of the initiative to reduce avoidable hospitalizations among nursing home residents.[10] The Skilled Nursing Facility (SNF) value-based purchasing program took effect in October 2018 to extend penalties for excess readmissions to SNFs; preliminary data suggest that 73% of SNFs face financial penalties after failing to achieve benchmarks.[51]

Previous research in long-term care settings has focused almost exclusively on potentially avoidable hospitalizations. The present study extends prior work to include all potentially avoidable hospital transfers, including ED visits and observation stays. We found that declines in all-cause hospital transfer rates were almost exclusively associated with reductions in acute hospitalizations, and the rates of observation stays remained low between 2011 and 2017. Thus, concerns that hospitals may shift admissions to observation stay status to avoid HRRP penalties[18] appear to be unfounded in this population. In addition, rates of decline were similar for all-cause and potentially avoidable transfers, suggesting that broader efforts are being made to reduce hospital transfers or that there is a spillover effect from the focus on potentially avoidable conditions. Although we observed reductions in potentially avoidable hospital transfers, several thousand nursing home residents with advanced illness continue to be transferred to hospitals near the end of life. We estimated 708 096 transfers for all-cause transfers across the 3 advanced illness cohorts from 2011 to 2017, of which 259 339 (36.8%) were potentially avoidable. Moreover, despite the initial reduction in potentially avoidable transfers from 39.1% in 2011 to 35.1% in 2013, the rate appears to have rebounded to 37.7% by 2016 (eTable 2 and eFigure in the Supplement).

Limitations

This study has limitations. The application of claims-based measures of potentially avoidable conditions to nursing home populations remains controversial because they do not capture the complex health status of frail, older nursing home residents with multimorbid conditions or the specific challenges of managing acute illnesses in this population and setting.[7,45] Moreover, insurance claims and MDS 3.0

assessments do not fully capture the circumstances leading to decisions for hospital transfer, including advance directives. Important drivers of decisions to transfer are associated with decisional processes and organizational factors, including communication, family preferences, and nursing home resources.[52-56] Furthermore, the principal diagnoses listed on hospital claims are assigned at discharge as the diagnosis that was chiefly responsible for the admission, whereas the diagnosis assigned to an ED visit or observation stay is based on more limited information.[57] However, we focused on long-term care residents with advanced illness for whom care decisions should align with values and goals of care and for whom the harms associated with hospital transfers usually outweigh possible benefits.[3-5]

Conclusions

Hospital transfer rates for all causes and for potentially avoidable causes declined in 2017 compared with 2011 for long-stay nursing home residents with advanced dementia, CHF, or COPD, with no increase in mortality. Reductions in potentially avoidable transfers are encouraging, yet many residents still experienced multiple transfers for infections and CHF or COPD exacerbations. These findings indicate important opportunities to improve care of nursing home residents with advanced illness through improvements in advance care planning, acute care management, and the delivery of high-quality palliative care.

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Letters

RESEARCH LETTER

Temporal Trends in the Numbers of Skilled Nursing Facility Specialists From 2007 Through 2014

Residents of nursing homes (NHs) comprise a medically complex and vulnerable population with many persons experiencing multiple comorbid conditions, frailty, and advanced dementia. Health care professionals such as physicians, nurse practitioners (NPs), and physician assistants (PAs) play an important role in managing their care. An Office of Inspector General Report[1] noted that specialization of health care professionals in NH care could potentially improve care through increased presence of health care professionals in NHs, enhanced knowledge in the care of patients with medically complex conditions, and better understanding of the regulatory environment. On the contrary, specialization in 1 setting of care could result in increased fragmentation of care, giving rise to concerns about medical errors and lack of care coordination. Little empirical research is available about the number of clinicians who primarily practice in NHs or the proportion of NH care delivered by these clinicians.[2] Using national Medicare Part B claims from 2007, 2010, and 2014, we characterized temporal trends in the number of physicians, NPs, and PAs concentrating their practice in the NH or skilled nursing facility (SNF) setting (ie, SNFists), the fraction of all NH and SNF claims generated by SNFists, and state variation in this phenomenon in 2014.

Editor's Note

Methods | The Medicare Part B Carrier File includes Evaluation and Management codes based on common sites of service: the nursing home, outpatient office, hospital, emergency department, a patient's home, and assisted living, custodial care facilities. Using Evaluation and Management codes from 20% of all Medicare Part B Carrier file claims from 2007, 2010, and 2014, we identified all physicians, NPs, and PAs who billed more than 90% of all their visits in the NH setting. The 90% threshold is consistent with a prior study of hospitalist care in the United States[3]; in a sensitivity analysis, we relaxed this threshold to 50%. Temporal trend comparisons for 2007, 2010, and 2014 were performed using variance-weighted least squares. We further characterized, in each state, the fraction of all outpatient visits in NHs that were accounted for by SNFists. An institutional review board waiver was obtained from Brown University.

Results | Between 2007 and 2014, the proportion of physicians ever billing in an NH decreased from 13.7% to 9.8% (test of trend, $P < .001$) while the number of physicians classified as SNFists increased by 48.2% (1496 vs 2225), increasing from 0.34% to 0.49% of all physicians (**Table**). The number of NPs or PAs classified as SNFists nearly doubled (1678 vs 3074). The proportion of NPs and PAs classified as SNFists remained stable because of increasing numbers of these clinicians. The proportion of all Evaluation and Management bills for care in an NH or SNF submitted by clinicians classified as SNFists increased from 11.6% to 14.3% among physicians (test of trend, $P < .001$) and from 10.4% to 17.2% among NPs and PAs (test of trend, $P < .001$). Between 2007 and 2014, the proportion of total SNF billing accounted for by SNFist clinicians increased from 22.0% to 31.5% (test of trend, $P < .001$). The SNFists' proportion of total NH billing varied by state, amounting to nearly 50% in Delaware, Hawaii, Tennessee, Connecticut, and Massachusetts. In a sensitivity analysis using a threshold of more than 50% of visits in the SNF, the number of physician SNFists increased from 2551 to 3529 and the number of NP or PA SNFists increased from 3267 to 5477.

Table. Physician, Nurse Practitioner, and Physician Assistant Billing in 2007, 2010, and 2014

Billing Category	2007	2010	2014
Physicians, No.	435 943	419 299	459 895
Ever billing in an SNF,[a] No. (%)	59 724 (13.7)	50 814 (12.1)	45 070 (9.8)
Billing ≥90% in an SNF,[a] No. (%)	1496 (0.34)	1697 (0.40)	2225 (0.49)
Nurse practitioners or physician assistants, No.	64 393	80 029	131 986
Ever billing in an SNF,[b] No. (%)	7528 (11.7)	8309 (10.4)	12 470 (9.5)
Billing ≥90% in an SNF,[b] No. (%)	1678 (2.6)	2031 (2.5)	3074 (2.3)
Evaluation and management code bills at SNF, No.	4 731 367	4 538 967	5 205 865
By physician billing ≥90% in an SNF,[c] No. (%)	550 425 (11.6)	584 952 (12.9)	747 106 (14.3)
By nurse practitioner or physician assistant billing ≥90% in an SNF,[c] No. (%)	49 145 (10.4)	581 235 (12.8)	895 830 (17.2)

Abbreviation: SNF, skilled nursing facility.

[a] For the physicians ever billing in an SNF or physicians billing 90% or more in an SNF, the denominator is physicians billing Medicare in that year.

[b] For nurse practitioner or physician assistant billing, the denominator is nurse practitioners or physician assistants billing Medicare in that year.

[c] The denominator for physicians, nurse practitioners, and physician assistants billing at 90% or more is the number of evaluation and management codes billed in a nursing home or SNF in the year 2007, 2010, or 2014.

Discussion | The care of frail and medically complex NH residents is increasingly performed by NPs and PAs who focus nearly exclusively in this site of care. In some states, SNFists accounted for nearly half of the total billing in the NH setting of care. Future research is needed to understand how this specialization of care affects not only care delivery but the overall experience of frail, elderly patients.

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Study concept and design: Teno, Gozalo, Trivedi, Mitchell, Bunker, Mor.
Acquisition, analysis, or interpretation of data: Teno, Gozalo, Bunker, Mor.
Drafting of the manuscript: Teno, Bunker.
Critical revision of the manuscript for important intellectual content: Teno, Gozalo, Trivedi, Mitchell, Mor.
Statistical analysis: Teno, Gozalo.
Obtained funding: Teno, Mor.
Administrative, technical, or material support: Teno, Gozalo, Bunker, Mor.
Supervision: Teno, Gozalo, Mor.

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Letters

RESEARCH LETTER

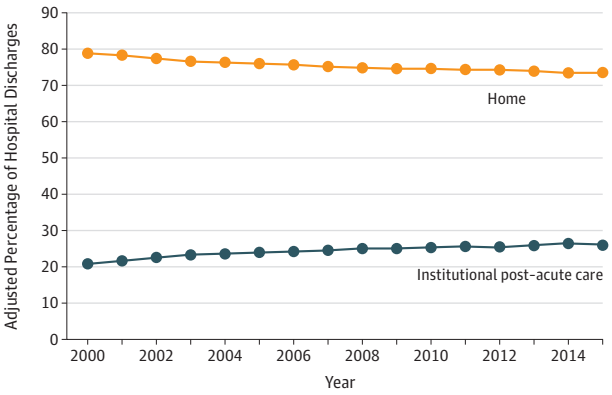
Trends in Post-Acute Care Use Among Medicare Beneficiaries: 2000 to 2015

Since Medicare's adoption of the inpatient prospective payment system in 1983, hospitals have sought ways to reduce costs, resulting in a decrease in hospital length of stay and an increase in the use of institutional post-acute care,[1] making it a major Medicare expenditure.[2] Since the Affordable Care Act passed in 2010, Medicare has implemented payment reforms designed to make hospitals and clinicians accountable for the cost and quality of care delivered. Examples include the Hospital Readmissions Reduction Program (implemented in 2012), accountable care organizations (2012), and bundled payments (2013). How these payment reforms affect the use of post-acute care is unknown.[3] The expense of post-acute care may diminish its use under cost-containment incentives.[4] Alternatively, pressure to reduce costs by reducing unnecessary readmissions may encourage its use. Our objective was to document recent trends in use of institutional post-acute care (including the 2 most common sites: skilled nursing facilities [SNFs] and inpatient rehabilitation facilities [IRFs]) and, simultaneously, hospital and post-acute care length of stay.

Methods | We used the 100% MedPAR file[5] to identify Medicare beneficiaries discharged alive from an acute care hospital between January 2000 and December 2015 (n = 199 069 327), excluding discharges younger than 65 years or discharged to hospice (n = 39 036 324 or 19.6%), enrolled in Medicare Advantage (n = 20 250 852 or 10.2%), or discharged to institutional settings other than SNF or IRF (eg, psychiatric hospital; n = 1 808 518 or 0.9%). We identified each discharge's first post-hospitalization destination (home vs institutional post-acute care) and the number of days in the hospital and post-acute care. We used multivariable regression to predict risk-adjusted annual outcomes adjusted for age, sex, race, and 31 Elixhauser comorbidities. We tested for the statistical significance of differences over time using *t* tests (2-tailed with an α of .05). All analyses were performed using Stata (StataCorp), version 15. This study was approved by the institutional review board of the University of Pennsylvania with a waiver of informed consent.

Results | Among 137 973 633 hospital discharges, 20.3% were discharged to SNFs and 3.7% were discharged to IRFs. The adjusted percentage of hospital discharges to post-acute care increased from 21.0% in 2000 to 26.3% in 2015 (increase of 5.36 percentage points [95% CI, 5.32 to 5.40]; *P* <.001), whereas the adjusted percentage of discharges home decreased from 79.0% in 2000 to 73.6% in 2015 (decrease of 5.36 percentage points [95% CI ,−5.40 to −5.32]; *P* <.001) (**Figure 1**).

Figure 1. Proportion of Medicare Beneficiaries Discharged to Institutional Post-Acute Care vs Discharged Home



Estimates are adjusted for patient age, sex, race, and Elixhauser comorbidities. The median number of hospital discharges to home per year was 6 664 718 (interquartile range [IQR], 5 768 018-7 367 173) and the median number of discharges to post–acute care per year was 2 151 959 (IQR, 1 978 709-2 199 801).

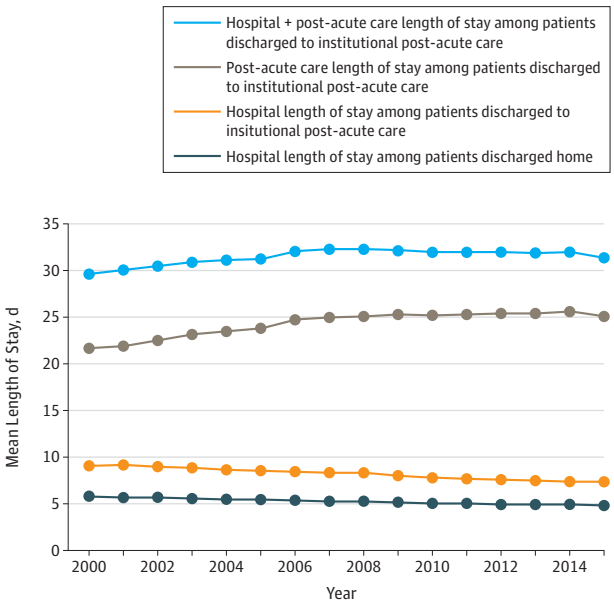
Among patients discharged to post-acute care, hospital length of stay decreased from 9.0 days in 2000 to 7.3 days in 2015 (decrease of 1.70 days [95% CI, −1.71 to −1.69]; *P* <.001) (**Figure 2**). Among patients discharged home, hospital stays decreased from 5.7 days in 2000 to 4.8 days in 2015 (decrease of −0.91 days [95% CI, −0.92 to −0.91]; *P* <.001). At the same time, length of stay in post-acute care increased from 21.7 days in 2000 to 25.7 days in 2014 (increase of 3.98 days [95% CI, 3.93 to 4.02]; *P* < .001) and then decreased to 25.1 days in 2015 (decrease of 0.54 days [95% CI, 0.50 to 0.59]; *P* < .001).

Discussion | The use of institutional post-acute care increased between 2000 and 2015 and was accompanied by increasing length of post-acute care stays through 2014. These trends did not appear to change when payment reform was implemented under the Affordable Care Act. SNFs (which accounted for 85% of institutional post-acute care) are paid per diem and thus may have strong incentives to maintain longer lengths of stay. This study was limited by the exclusion of Medicare Advantage enrollees. If policy incentives are to effectively reduce SNF length of stay, they might need to align SNF payment with the goal of reducing SNF use.

It is uncertain whether the use of post-acute care benefits patients. Despite its proliferation, there is little evidence that post-acute care improves key patient outcomes—preventing rehospitalizations or improving functional recovery. Further investigating how post-acute care affects patient outcomes is essential.

Rachel M. Werner, MD, PhD
R. Tamara Konetzka, PhD

Figure 2. Mean Length of Stay in the Hospital, in Post–Acute Care, and in the Combination of Hospital Plus Post–Acute Care



Estimates are adjusted for patient age, sex, race, and Elixhauser comorbidities. The median number of hospital discharges to home per year was 6 664 718 (interquartile range [IQR], 5 768 018-7 367 173) and the median number of discharges to post–acute care per year was 2 151 959 (IQR, 1 978 709-2 199 801).

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Author Contributions: Dr Werner had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
Concept and design: Both authors.
Acquisition, analysis, or interpretation of data: Werner.
Drafting of the manuscript: Werner.
Critical revision of the manuscript for important intellectual content: Both authors.
Statistical analysis: Both authors.
Obtained funding: Werner.

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COMMENT & RESPONSE

Diagnosis and Treatment of Hidradenitis Suppurativa

To the Editor Drs Saunte and Jemec performed an illustrative review focused on the advances in diagnosis and treatment of hidradenitis suppurativa (HS).[1] However, the advances in imaging of the disease were not discussed.

For example, regarding the pathogenesis, ultrasound studies have allowed visualization of the hidden connections between the tunnels or fistulous tracts and fluid collections and the dilated and ruptured base of the hair follicles, which were illustrated in Figure 3 in the article.[1-3] Regarding the staging of hidradenitis, ultrasonography has also demonstrated that clinical evaluation and commonly used clinical scoring systems can miscategorize as healthy skin corporal segments with fluid collections or fistulous tracts underneath.[3] The latter findings on imaging can be critical because, as pointed out by the authors, the choice of therapy is guided by disease severity. Currently, color Doppler ultrasound can support the detection of key subclinical lesions, the staging of the disease, and the assessment of activity and has been added to the clinical evaluation of hidradenitis in many centers around the world.[3,4] Moreover, ultrasound is also being used in ongoing trials.

In patients with indications for local or systemic treatments, imaging can be a noninvasive tool for monitoring the response. In patients with a surgical indication, an image-guided mapping of the extent of the abnormalities can be performed. Ultrasound has the ability to detect, categorize, and measure the lesions in all the corporal regions affected by hidradenitis.[3] This imaging information may allow better selection of the type of medical treatment or the location and extent of the surgical incision.[3]

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CLINICAL INVESTIGATION

Successful Discharge to Community Gap of FFS Medicare Beneficiaries With and Without ADRD Narrowed

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BACKGROUND/OBJECTIVES: We sought to compare the post-acute and long-term care experience of Medicare beneficiaries with and without Alzheimer Disease and Related Dementias (ADRD), and whether differences changed from January 1, 2007 to September 30, 2015.

DESIGN: Retrospective cross-sectional trend study using Medicare claims linked to the Centers for Medicare & Medicaid Services' (CMS) Minimum Data Set.

SETTING: CMS-certified skilled nursing facilities (skilled nursing facility (SNF), n = 17,043).

PARTICIPANTS: Fee-for-service Medicare beneficiaries aged ≥66 years (n = 6,614,939) discharged from a hospital to a SNF who had not lived in a nursing home during the year before hospitalization.

MEASUREMENTS: ADRD was defined by the Chronic Condition Data Warehouse. Outcome measures included: (1) successful discharge defined as being in SNF less than 90 days, then discharged back to the community, alive without subsequent inpatient health care for 30 continuous days; (2) became long-stay resident in SNF; (3) death in SNF within 90 days; (4) hospital readmission within 30 days of entering SNF; and (5) transferred to another nursing home within 30 days of entering SNF.

RESULTS: Successful discharge of beneficiaries with ADRD increased from 43.4% in 2007 to 53.9% in 2015 (average annual percent change (AAPC) = 2.1 (95% CI = 2.0–2.2)); those without ADRD also increased (from 59.1% to 63.6%, AAPC = 0.9 (95% CI = 0.7–1.1)) but not as fast as those with ADRD ($P < .01$). The proportion of all beneficiaries who became long-stay or were readmitted to the hospital decreased ($P < .05$). The proportion with ADRD who became long-stay was nearly three times higher than those without throughout the study (15.0% vs 5.5% in 2007; 11.3% vs 4.3% in 2015).

CONCLUSION: Though disparity in ADRD in becoming long-stay residents remains, the increase in successful discharges among those with ADRD also stresses the increasing importance of community as a care setting for adults with ADRD. **J Am Geriatr Soc 00:1-7, 2020.**

Keywords: ADRD; successful discharge; disparity

INTRODUCTION

Between 2010 and 2016 20.3% of Medicare beneficiaries received post-acute care (PAC) services in a skilled nursing facility (SNF) after being discharged from the hospital.[1] The improving Medicare Post-Acute-Care Transformation Act of 2014 mandated addition of a national quality measure for successful community discharge from PAC services. Although the goal of PAC rehabilitation is to maximize independence and facilitate a safe community transition, some SNF patients may be awaiting family arrangements to provide care at home or for selection of a long-term nursing facility. Some may need to stabilize and to get their numerous medical conditions to a manageable care plan. But generally, returning to and remaining in the community after an illness, injury, or surgery reflects the quality of PAC[2] (https://impactcollaboratory.org/). Although some studies have assessed inpatient rehabilitation facilities patients' success in

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community discharge,[3,4] little is known about SNF patients' success in returning and staying home post-discharge.

SNF admission is often the gateway to becoming a long-term nursing home resident. And, Alzheimer Disease and Related Dementias (ADRD) patients are more likely to become long-stay residents. The Affordable Care Act (ACA) and other policy initiatives strongly encourage community based long-term care for ADRD patients.[5] In 2012, under the ACA the Centers for Medicare & Medicaid Services (CMS) could penalize hospitals for readmissions in less than 30 days for certain conditions. Successful transitioning from the hospital to a SNF is even more complicated for persons with ADRD. For example, patients with ADRD whose behavioral problems surpass the SNF's capacity to accommodate them are at high risk of rehospitalization or transfer to a different SNF.[6] For this reason, SNF administrators may be less likely to accept patients with ADRD after acute hospitalization. Indeed, one study reported that SNF personnel believe hospital personnel downplay ADRD patients' behavioral problems to increase their chances of SNF admission.[6] For these reasons, real and perceived about patients with ADRD, we hypothesized that Medicare beneficiaries with ADRD would experience more negative outcomes than those without ADRD, in terms of their likelihood of successfully returning home, experiencing rehospitalization, dying in the SNF, becoming a permanent nursing home resident, or transferring to another SNF, and we assessed whether the differences changed between 2007 and 2015.

METHODS

Study Population

Our sample was drawn from 100% of Medicare SNF claims linked to the CMS Minimum Data Set, which are mandatory clinical assessments for all nursing home residents of Medicare-certified nursing homes, from January 1, 2007 through September 30, 2015 (with follow-up for post-discharge outcomes dated through December 31, 2015). The study period was chosen to include only events occurring before the introduction of the ICD-10 coding system. We included fee-for-service Medicare beneficiaries aged ≥66 years who were discharged alive from the hospital and admitted to a SNF within 1 day of hospital discharge. We excluded those with history of being in a nursing home within the 12 months (using the MDS) before hospital admission because they were likely to be sicker and/or more severely demented.[7]

Main Exposure Measure

We identified Medicare beneficiaries with ADRD using the Chronic Condition Data Warehouse (CCW) flag in the Medicare beneficiary summary file as of the day of hospital discharge. The CCW algorithm identifies beneficiaries as having ADRD if they have one of 24 ICD-9 codes present on one or more inpatient, SNF, HHA, outpatient, or carrier claim over a 3-year look-back period.[8] This definition has a sensitivity (0.85) and specificity (0.89).[9] We believe this is sufficient to assess changes in trends because (1) the measure did not change during the study period (ICD-9 codes were used throughout) and (2) we hypothesized post-discharge outcomes of ADRD patients may differ from those without ADRD, in part due to perceptions of ADRD patients. In other words, regardless of truly having ADRD, if beneficiaries' have an ADRD diagnosis, then healthcare providers perceive that they have ADRD.

Outcome Measures

We assessed trends over our study period in seven outcome measures. First, we defined successful discharge as being discharged alive from a SNF to the community within 90 days of SNF admission without subsequent inpatient healthcare utilization for 30 continuous days. Second, we defined becoming a long-stay resident as remaining in the SNF more than 90 days after SNF admission. Third, we defined dying in the SNF as dying within 90 days of SNF admission. Fourth, we assessed death within 90 days after discharge from the SNF (after being in the SNF at least 90 days). We assessed rehospitalization two ways: within 30 days and within 90 of hospital discharge. For both rehospitalization measures, those who died in the same

Table 1. Characteristics of Medicare Beneficiaries Aged 66 years and Older with Hospital Discharge to Nursing Home

	January 1 to December 31, 2007		January 1 to December 31, 2011		January 1 to September 30, 2015	
	ADRD N = 211,518	No ADRD N = 406,667	ADRD N = 277,751	No ADRD N = 484,728	ADRD N = 217,990	No ADRD N = 370,702
Age, mean	84.1	80.5	84.5	80.3	84.6	80.0
Female (%)	67.0	67.7	66.5	66.9	64.9	64.9
Black (%)	8.0	6.2	8.4	6.6	8.6	6.9
Other race (%)	3.4	3.1	4.1	3.5	4.6	3.9
Dual eligible (%)	18.0	11.4	18.1	11.0	16.9	10.3
# of hospitalized days, mean	8.1	8.6	7.6	7.8	7.4	7.7
Residential ZIP code Medicare Advantage penetration, mean %	17.8	17.6	22.7	22.4	28.7	28.1
Residential ZIP code dual-eligible rate, mean %	13.0	12.5	13.1	12.5	12.7	12.2

Table 2. FFS Medicare Beneficiaries Aged >65 Years Discharged from Hospital to SNF by Year, January 1, 2007 Through September 30, 2015

Discharge: Categories	AAPC (95% CI)	2007 N = 211,518	2008 N = 271,953	2009 N = 265,601	2010 N = 279,013	2011 N = 277,751	2012 N = 282,761	2013 N = 283,171	2014 N = 288,361	2015 N = 217,990
With Alzheimer's disease and other related dementias										
Successful discharge SNF to community	2.0 (1.8,2.2)	43.5%	44.1%	45.7%	46.5%	47.4%	48.3%	49.3%	50.1%	50.9%
Long-stay	−3.6 (−4.4, −2.8)	15.0%	14.2%	13.4%	12.5%	12.2%	11.8%	11.7%	11.3%	11.3%
Death in SNF	−0.7 (−1.1, −0.3)	16.9%	17.0%	16.2%	16.3%	16.1%	16.4%	16.2%	16.1%	15.8%
Death within 90 days of discharge from SNF	−0.2 (−1.0, 0.7)	8.9%	8.3%	8.2%	8.4%	8.4%	8.6%	8.4%	8.6%	8.2%
Re-entered hospital within 30 days	−2.8 (−3.6, −2.0)	16.0%	16.4%	16.1%	15.8%	15.3%	14.5%	13.8%	13.5%	13.4%
Re-entered hospital within 90 days	−1.7 (−2.3, −1.2)	27.4%	27.8%	27.4%	27.3%	26.6%	25.9%	24.8%	24.8%	24.6%
Patient was transferred from SNF to another facility within 30 days	−2.0 (−3.3, −0.7)	5.0%	4.7%	4.5%	4.2%	4.2%	4.1%	4.1%	4.3%	4.3%
		N = 406,667	N = 507,801	N = 497,452	N = 510,887	N = 484,728	N = 480,412	N = 488,342	N = 489,829	N = 370,702
Without Alzheimer's disease and other related dementias										
Successful discharge SNF to community	1.0 (0.8,1.2)	59.0%	58.6%	59.5%	60.1%	61.1%	61.8%	62.5%	62.7%	62.9%
Long-stay	−3.4 (−4.3, −2.6)	5.5%	5.3%	5.0%	4.8%	4.6%	4.4%	4.4%	4.3%	4.3%
Death in SNF	−1.4 (−1.8, −0.9)	13.9%	14.0%	13.5%	13.2%	12.9%	12.9%	12.8%	12.8%	12.8%
Death within 90 days of discharge from SNF	−1.1 (−1.5, −0.6)	6.3%	6.2%	6.1%	6.0%	5.9%	5.9%	5.7%	5.9%	5.7%
Re-entered hospital within 30 days	−2.9 (−3.6, −2.1)	16.5%	16.8%	16.4%	16.1%	15.5%	14.7%	14.0%	13.8%	13.9%
Re-entered hospital within 90 days	−2.1 (−2.7, −1.5)	26.8%	27.2%	26.7%	26.3%	25.5%	24.6%	23.6%	23.5%	23.6%
Patient was transferred from SNF to another facility within 30 days	−3.1 (−4.4, −1.8)	3.5%	3.3%	3.1%	2.9%	2.8%	2.7%	2.7%	2.7%	2.8%

Note: All years are from January 1 to December 31, except 2015 is from January 1 to September 30. Adjusted for age, sex, race, dual eligible status, % MA penetration in zipcode, % dual eligible in zipcode. AAPC, average annual percentage change; CI, confidence interval; died in SNF, within 30 days of entering SNF; FFS, fee-for-service; long-stay, still in SNF after 90 days of entering; SNF, skilled nursing facility; successful discharge, in SNF 90 days, then they were discharged back to the community, alive without subsequent inpatient healthcare utilization for 30 continuous days.

timeframe were censored. Finally, we assessed transfer to another NH within 30 days of entering the SNF. To clarify "SNF," our focus is not on SNF coverage for payment, but rather PAC in a SNF which is typically short-stay or ≤90 days. We used the sequence of claims and the MDS to identify outcomes.

Statistical Analyses

First, we assessed the overall change in number of beneficiaries with and without ADRD from 2007 to 2014 (for this we excluded 2015 because it was a partial year). Trends for each outcome were then assessed on annual cohorts of beneficiaries who were discharged from the hospital to a SNF, adjusting for age, sex, race, dual-eligibility, Medicare Advantage penetration (zipcode of residence), and percent dual-eligible (zipcode of residence). We used STATA version 16 software to obtain adjusted predictive margins and standard errors. We evaluated monotonic trends by joinpoint regression using Joinpoint software,[10] which has the same underlying assumptions as simple regression and allows for input of estimates and standard errors. To determine if the trend was statistically significant we used the average annual percent change (AAPC) and its associated *P*-value. We also compared AAPC differences in trends between those with and without ADRD. All analyses were stratified by beneficiary ADRD status.

Sensitivity Analyses

Because our analyses included all FFS beneficiaries discharged from the hospital to a SNF, we wanted to determine if results would be similar for a more homogenous group or if our findings were driven by certain subgroups. Therefore, we performed the same trend analyses for patients hospitalized for hip fractures and were discharged from the hospital to a SNF. Codes used to define hip fractures were 820.xx.

All analyses were conducted after establishing a data use agreement with CMS and obtaining final approval from Brown University's Institutional Review Board.

RESULTS

We identified 2,134,798 beneficiaries with prevalent ADRD (243,321 or 11.4% were included in multiple years) and 3,582,546 without (654,274 or 18.3% were included in multiple years) who otherwise met study eligibility criteria. The average age of beneficiaries with ADRD discharged from hospital to SNF was close to 84 years in 2007, 2011, and 2015; the average age of those without ADRD was approximately 80 years at the beginning, middle, and end of the study (Table 1). About two-thirds of those with and without ADRD were female. The average proportion with Medicare Advantage penetration in the residents' zip code increased from 2007 to 2015 for those with (17.8%–28.7%) and without ADRD (17.6%–28.1%). A few (7.4% n = 486,715) of beneficiaries were referred to a hospice within 90 days of entering the SNF or in the 90 days following SNF discharge; of those, 85.2% died.

The number of beneficiaries with ADRD discharged from the hospital to a SNF increased 36.3% from 211,518 in 2007 to 288,361 in 2014 (2015 was a partial year, AAPC = 3.1 (0.3, 5.9)). There was no significant change in the number of beneficiaries without ADRD discharged from the hospital to a SNF from 2007 to 2014 (AAPC = 1.1 (−1.6, 3.9)). The proportion of traditional Medicare beneficiaries with ADRD who had a successful discharge from the SNF to the community increased from 43.5% in 2007 to 50.9% in 2015 (AAPC = 2.0 (1.8, 2.2)) (Table 2 and Figure 1). Successful discharge for those without ADRD also increased (from 59.0% to 62.9%, AAPC = 1.0 (0.8, 1.2)), but not as fast as for those with ADRD (AAPC difference (ADRD − No ADRD) = 1.0 (0.8, 1.2), $P < .01$). The proportion of beneficiaries with ADRD who became long-stay nursing home residents decreased (from 15.0% in 2007 to 11.3% in 2015, AAPC = −3.6 (−4.4, −2.8)); those without ADRD decreased also (from 5.5% to 4.3%, AAPC = −3.4 (−4.3, −2.6)) similar to those with ADRD ($P = .70$). However, the proportion of those with ADRD who became long-stay was nearly three times higher than those without. The proportion of beneficiaries with ADRD who died within 90 days of entering the SNF decreased from 2007 (16.9%) to 2015 (15.8%, AAPC = −0.7 (−1.2, −0.2)); those without ADRD decreased as well from 13.9% in 2007 to 12.8% in 2015 (AAPC = −1.4 (−1.8, −0.9)), faster than those with ADRD (AAPC difference (ADRD − No ADRD) = 0.9 (1.7, 0.1), $P < .01$). The proportion of beneficiaries with ADRD who died within 90 days of discharge from the SNF did not change from 2007 (8.9%) to 2015 (8.2%, $P = .7$); those without ADRD decreased from 6.3% in 2007 to 5.7% in 2015 (AAPC = −1.1 (−1.5, −0.6)), faster than those with ADRD (AAPC difference (ADRD − No ADRD) = 0.9 (1.7, 0.1), $P < .01$). The

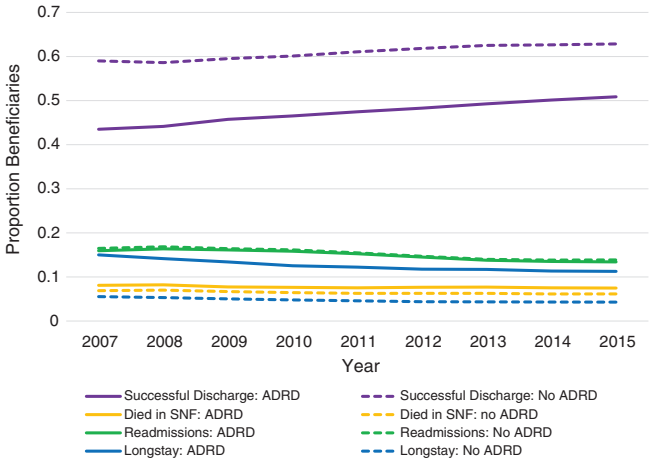

Figure 1. Adjusted proportion of FFS Medicare Beneficiaries aged >65 years discharged from hospital to SNF by ADRD status, January 1, 2007 through September 30, 2015. Adjusted for age, sex, race, dual eligible status, % MA penetration in zipcode, % dual eligible in zipcode. ADRD, Alzheimer's disease and related dementias; died in SNF, within 30 days of entering SNF; FFS, fee-for-service; long-stay, still in SNF after 90 days of entering; readmissions, readmitted to hospital within 30 days of entering SNF; SNF, skilled nursing facility; successful discharge, in SNF 90 days, then they were discharged back to the community, alive without subsequent inpatient healthcare utilization for 30 continuous days.

Table 3. FFS Medicare Beneficiaries Aged >65 Years Hospitalized for Hip Fractures and Discharged to SNF by Year, January 1, 2007 Through September 30, 2015

Discharge: Categories	AAPC (95% CI)	2007 N = 23,485	2008 N = 29,321	2009 N = 29,445	2010 N = 30,215	2011 N = 29,772	2012 N = 30,408	2013 N = 31,483	2014 N = 31,882	2015 N = 23,500
With Alzheimer's disease and other related dementias										
Successful discharge SNF to community	2.1 (1.8,2.4)	43.2%	44.0%	45.6%	46.1%	47.4%	47.6%	49.5%	50.6%	50.6%
Long-stay	−3.0 (−3.9, −2.1)	16.0%	14.7%	14.3%	13.5%	13.3%	12.9%	13.0%	12.3%	12.4%
Death in SNF	−1.4 (−2.2, −0.5)	16.1%	16.5%	14.8%	15.1%	14.9%	15.0%	14.7%	14.6%	14.5%
Death within 90 days of discharge from SNF	−0.2 (−1.2, 0.7)	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%	8.6%
Re-entered hospital within 30 days	−3.4 (−4.6, −2.3)	14.9%	15.6%	14.7%	14.9%	13.6%	13.2%	12.2%	12.0%	12.4%
Re-entered Hospital within 90 days	−2.3 (−3.3, −2.0)	23.8%	25.0%	24.2%	24.2%	22.8%	22.3%	20.9%	20.8%	21.6%
Patient was transferred from SNF to another facility within 30 days	−2.0 (−3.7, −0.3)	6.8%	6.1%	5.9%	5.5%	5.4%	5.5%	5.4%	5.7%	5.6%
		N = 36,725	N = 44,544	N = 43,394	N = 44,026	N = 41,341	N = 40,683	N = 41,740	N = 42,804	N = 31,612
Without Alzheimer's disease and other related dementias										
Successful discharge SNF to community	1.2 (1.1,1.4)	62.6%	62.9%	63.9%	63.9%	65.4%	65.8%	67.2%	67.7%	68.6%
Long-stay	−3.8 (−4.5, −3.0)	6.3%	5.8%	5.6%	5.4%	5.2%	5.0%	4.5%	4.7%	4.7%
Death in SNF	−2.9 (−3.7, −2.2)	9.2%	9.1%	8.8%	8.6%	7.8%	7.8%	7.7%	7.7%	7.3%
Death within 90 days of discharge from SNF	−1.5 (−2.7, −0.3)	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%	4.7%
Re-entered hospital within 30 days	−3.2 (−4.1, −2.4)	13.1%	13.4%	12.9%	12.9%	12.2%	11.9%	11.1%	10.6%	10.5%
Re-entered hospital within 90 days	−2.7 (−3.3, −2.0)	21.9%	21.8%	21.3%	21.4%	20.5%	19.9%	18.5%	18.4%	18.2%
Patient was transferred from SNF to another facility within 30 days	−4.2 (−5.4, −3.0)	5.1%	4.8%	4.5%	4.1%	3.9%	3.9%	3.7%	3.7%	3.8%

Note: All years are from January 1 to December 31, except 2015 is from January 1 to September 30. Adjusted for age, sex, race, dual eligible status, % MA penetration in zipcode, % dual eligible in zipcode. AAPC, average annual percentage change; CI, confidence interval; died in SNF, within 30 days of entering SNF; FFS, fee-for-service; long-stay, still in SNF after 90 days of entering; SNF, skilled nursing facility; successful discharge, in SNF 90 days, then they were discharged back to the community, alive without subsequent inpatient healthcare utilization for 30 continuous days.

proportion of beneficiaries discharged and rehospitalized within 30 days and 90 days decreased among both those with (AAPC = −2.8 (−3.6, −2.0) and AAPC = −1.7 (−2.3, −1.2)) and without ADRD (APC = −2.9 (−3.6, −2.1) and AAPC = −2.1 (−2.7, −1.5)) during the study period, though not significantly different from each other (P = .90 and P = .20, respectively). The proportion of beneficiaries discharged to SNF and transferred to another nursing facility decreased among both those with ADRD from 5.0% to 4.3% (AAPC = −2.0 (−3.3, −0.7)) and without ADRD from 3.5% to 2.8% (AAPC = −3.1 (−4.4, −1.8)), though not significantly different from each other (P = .20).

Results of Sensitivity Analyses

Overall, 9.5% of patients discharged had claims for being hospitalized with hip fracture. The number of beneficiaries discharged from the hospital to a SNF increased 35.8% from 23,485 in 2007 to 31,882 in 2014 (2015 was a partial year and therefore excluded, AAPC = 3.1 (0.7, 5.6)). There was no significant change in beneficiaries without ADRD discharged from the hospital to a SNF (AAPC = 0.6 (−1.8, 3.1). Those hospitalized for hip fracture, with and without ADRD, experienced more successful SNF-to-community discharges after acute hospitalization, fewer deaths, rehospitalizations, long-stays, and transfers to other nursing facilities within 30 days of entering the SNF from 2007 to 2015 (P < .05) (Table 3). The gap between those with and without ADRD in successful SNF-to-community discharges after acute hospitalization narrowed, as rates of successful discharges increased faster among those with ADRD (AAPC difference (ADRD − No ADRD) = 0.9 (0.6, 1.2)).

DISCUSSION

In general, traditional Medicare beneficiaries with ADRD have worse outcomes than those without ADRD, but the gap is narrowing with respect to returning home from the SNF, surviving and not being rehospitalized. From 2007 to 2015, Medicare beneficiaries experienced more successful SNF-to-community discharges after acute hospitalization, due to fewer rehospitalizations, long-stays, and transfers to other nursing facilities within 30 days of entering the SNF. The gap between those with and without ADRD in successful SNF-to-community discharges after acute hospitalization narrowed, as the rates of successful discharges increased faster among those with ADRD. Deaths within 90 days of discharge to SNF did not change among beneficiaries with ADRD, yet the mortality rate decreased among the non-ADRD group. Notably, the gap between those with and without ADRD in becoming long-stay remained; those with ADRD were nearly three times as likely to become long-stay residents.

Studies have reported an increase in the number of adults living with ADRD.[11] This is reflected in our study showing an increase in ADRD patients discharged from the hospital to the SNF overall and also in our sensitivity analysis among hospitalizations for hip fractures. Our results may indicate that the greater number of patients with ADRD discharged home may reflect healthier people being diagnosed with ADRD at earlier stages.

Higher rates of successful discharge from SNF to the community and fewer rehospitalizations, long-stays, and transfers to other nursing facilities among beneficiaries with ADRD over a decade are quite encouraging. Previous studies have reported persons with ADRD experience frequent transitions across the range of care, especially into and out of hospital and SNF settings.[12,13] And, nearly half of long-stay nursing home residents suffer from ADRD.[14,15] Our data suggest that the proportion of patients with ADRD who become long-stay residents after entering the SNF after being hospitalized is decreasing.

It is not surprising that rates of rehospitalization after hospital discharge to SNF decreased for all beneficiaries. In October 2012 a policy was mandated by the ACA to penalize hospitals with high readmission rates for certain conditions.[16] Readmission rates for some SNFs may have been high before 2012 because of the change in use of SNF care. Most SNFs (>90%) are dually certified as a SNF and as a nursing home.[17] Thus, a facility that offers skilled care often also provides long-term care services that Medicare does not cover. Ideally, SNF care is provided to restore function to patients discharged from acute hospital care before transitioning back to the community. In the decade before 2012, use of SNF care after acute hospitalization had greatly increased in part because of the shift of nursing homes from serving life long residents to facilities treating increasingly medically complex patients seeking PAC for recuperation after hospitalization. This may in part have been driven by a financial incentive to take advantage of the short-term Medicare benefit. Medicare covers up to 100 days after 3 days of hospitalization whereas Medicaid pays for most of long-term care, the Medicare payment for SNF services being higher than that for Medicaid. In other words, some patients may have been sent to the SNF as long as the financial benefit was available and then sent back to the hospital. Yet since the 2012 policy, that practice likely diminished.

Our result of decline in long-stay residents, with and without ADRD, helps to explain why occupancy in nursing homes continues to decline even though the number of beds has been steadily declining.[18-20] In nursing homes in states with no or nursing home-specific certificate-of-need programs (designed to curb healthcare spending), the number of beds has decreased since 1992.[21] The decline in long-stay residents may also be a reflection of the number of nursing home closures. Facilities with large proportions of long-stay residents tended to have high Medicaid occupancy,[22] and those facilities were most at risk of closure.[23]

Our study was subject to several limitations. First, discharge data for the Medicare Advantage population are not reliable and therefore were not included. Given the rapid growth of Medicare Advantage, which has a strong disincentive for hospital use, the results observed may not reflect the overall population aged 66 years and older. Second, the proportion of ADRD we reported likely includes some false-positive and false-negative ADRD cases; however, the CCW algorithm is the only approach that can identify a broad sample of beneficiaries with ADRD across community and nursing home settings in hospitalization data. Still, regardless of how ADRD is diagnosed, the trends reveal an increase in successful discharges but a steady gap in becoming long-stay residents with a nearly threefold risk among

those with ADRD. Third, we did not assess the geographic availability of PAC services; hence some patients may have been discharged to the community because of access rather than recovery. Fourth, we could not account for health beliefs, financial resources, availability of an appropriate caregiver (paid or unpaid), or cultural differences which may have influenced discharge to and remaining in the community. Finally, a potential limitation is that certain cohorts of beneficiaries discharged from the hospital to SNFs could have driven the results. However, sensitivity analyses confirmed overall results with a homogenous group. Among patients who had been hospitalized for hip fractures, trends for those with and without ADRD were in the same direction and the same estimates were statistically significant as were found for the overall group of beneficiaries with two exceptions.

We examined the trends in outcomes among Medicare beneficiaries discharged to SNF with and without a diagnosis of ADRD and found that many outcomes improved for all persons but that successful discharge rates, going home and remaining there, improved more rapidly for persons living with dementia than for persons without dementia. It may be that practices with regard to hospitalization may have influenced the trends in addition to practices in the SNF. Thus, more research is needed to understand what is driving the reduction in transfers, deaths, and long-stays among patients with ADRD discharged from hospital to SNF. In addition, the increase in successful SNF to community discharges stresses the increasing importance of community as the care setting for adults with ADRD.

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Conflict of Interest: BHB, MR, CK, and RMW have no conflicts of interest to report. VM receives compensation for his role as Chair of the Scientific Advisory Committee of naviHealth, a post-acute care convening company serving managed care companies and integrated hospital systems.

Author Contributions: VM and MR conceived and designed the study. BHB drafted the manuscript and did the statistical analyses. MR and CK obtained and compiled the data. All authors revised the report for intellectual content and contributed to the literature search. VM and RMW provided administrative, technical and material support.

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Tab 13 NF RUC Summary

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ISSUE: Nursing Facility

TAB: 13 AAPM&R, ACP, AGS, AMDA, ANA, APMA

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	86	0.055	0.046			1.60			35	5					25			5					
2nd REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	46	0.055	0.047			0.93			20	2					15			3					
CURRENT	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.052	0.038			1.64			43	10					23			10					
SVY	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a		203	0.058	0.047	0.50	1.50	1.70	2.00	30.00	36	6			0	20	25	30	120	5	0	0	2	12	1150
REC	99304	XXX	Initial nursing facility care, per day, for the evaluation and			0.050	0.042			1.50			36	6					25			5					
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and	2019-04	108	0.054	0.043			2.60			60	10					40			10					
2nd REF	99203	XXX	Office or other outpatient visit for the evaluation and	2019-04	25	0.055	0.046			1.60			35	5					25			5					
CURRENT	99305	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.055	0.041			2.35			57	11					33			13					
SVY	99305	XXX	Initial nursing facility care, per day, for the evaluation and		204	0.066	0.050	0.75	2.50	2.75	3.00	4.75	55	10			6	25	35	45	180	10	0	5	21	81	962
REC	99305	XXX	Initial nursing facility care, per day, for the evaluation and			0.059	0.045			2.50			55	10					35			10					
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and	2019-04	129	0.048	0.040			3.50			88	14					59			15					
2nd REF	99496	XXX	Transitional Care Management Services with the following	2018-10	30	0.051	0.051			3.79			75						75								
CURRENT	99306	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.051	0.038			3.06			80	15					45			20					
SVY	99306	XXX	Initial nursing facility care, per day, for the evaluation and		208	0.062	0.047	1.00	3.50	3.75	4.00	5.90	80	15			9	35	50	65	340	15	0	10	50	150	1500
REC	99306	XXX	Initial nursing facility care, per day, for the evaluation and			0.057	0.044			3.50			80	15					50			15					
1st REF	99212	XXX	Office or other outpatient visit for the evaluation and	2019-04	130	0.053	0.044			0.70			16	2					11			3					
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	43	0.054	0.043			1.30			30	5					20			5					
CURRENT	99307	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.054	0.038			0.76			20	5					10			5					
SVY	99307	XXX	Subsequent nursing facility care, per day, for the evaluation		196	0.063	0.057	0.18	0.70	0.80	1.30	4.00	14	1			0	10	12	15	120	1	0	0	10	49	3000
REC	99307	XXX	Subsequent nursing facility care, per day, for the evaluation			0.055	0.050			0.70			14	1					12			1					
1st REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	140	0.054	0.043			1.30			30	5					20			5					
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.051	0.041			1.92			47	7					30			10					
CURRENT	99308	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.053	0.037			1.16			31	7					15			9					
SVY	99308	XXX	Subsequent nursing facility care, per day, for the evaluation		214	0.069	0.053	0.50	1.30	1.44	1.85	5.00	27	5			3	15	18	25	120	4	0	20	100	350	6000
REC	99308	XXX	Subsequent nursing facility care, per day, for the evaluation			0.061	0.048			1.30			27	5					18			4					

Tab 13 NF RUC Summary

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
15					RUC				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	Global	DESC	Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
47	1st REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	149	0.051	0.041			1.92			47	7					30			10					
48	2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	34	0.050	0.040			2.80			70	10					45			15					
49	CURRENT	99309	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.044	0.034			1.55			45	10					25			10					
50	SVY	99309	XXX	Subsequent nursing facility care, per day, for the evaluation		217	0.057	0.044	0.75	1.92	2.09	2.60	6.00	47	7			5	20	30	35	120	10	0	30	100	355	2000
51	REC	99309	XXX	Subsequent nursing facility care, per day, for the evaluation			0.051	0.041			1.92			47	7					30			10					
52																												
53	1st REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	147	0.050	0.040			2.80			70	10					45			15					
54	2nd REF	99291	XXX	Critical care, evaluation and management of the critically ill	2005-08	19	0.096	0.064			4.50			70	15					40			15					
55	CURRENT	99310	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.045	0.034			2.35			70	15					35			20					
56	SVY	99310	XXX	Subsequent nursing facility care, per day, for the evaluation		203	0.054	0.043	1.00	2.80	3.00	3.60	7.00	70	10			0	30	45	55	180	15	0	2	15	50	1500
57	REC	99310	XXX	Subsequent nursing facility care, per day, for the evaluation			0.050	0.040			2.80			70	10					45			15					
58																												
59		99318	XXX	Evaluation and management of a patient involving an annual nursing	2007-02	CODE will be deleted	0.047	0.036			1.71			47	10					27			10					

Tab 13 NF RUC Summary

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ISSUE: Nursing Facility

TAB: 13 AAPM&R, ACP, AGS, AMDA, ANA, APMA

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	86	0.055	0.046			1.60			35	5					25			5					
2nd REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	46	0.055	0.047			0.93			20	2					15			3					
CURRENT	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.052	0.038			1.64			43	10					23			10					
SVY	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a		203	0.058	0.047	0.50	1.50	1.70	2.00	30.00	36	6			0	20	25	30	120	5	0	0	2	12	1150
AMDA	99304	XXX	Initial NF, PD, SF or low MDM	AMDA	112	0.056	0.045	0.70	1.48	1.65	2.00	30.00	36.5	7			0	20	25	31	120	5	0	0	5	15	750
AAPM&R	99304	XXX	Initial NF, PD, SF or low MDM	AAPM&R	15	0.072	0.059	0.93	1.60	2.00	2.55	3.50	34	4			10	20	25	30	60	5	0	0	0	16	75
ACP	99304	XXX	Initial NF, PD, SF or low MDM	ACP	7	0.079	0.060	0.93	1.34	1.80	2.35	2.75	30	5			5	19	20	25	35	5	0	0	5	8	100
AGS	99304	XXX	Initial NF, PD, SF or low MDM	AGS	41	0.049	0.040	0.50	1.60	1.80	2.60	4.00	45	10			0	20	30	30	120	5	0	0	0	4	300
ANA	99304	XXX	Initial NF, PD, SF or low MDM	ANA	1	0.013	0.017	0.95	0.95	0.95	0.95	0.95	55	10			30	30	30	30	30	15	0	0	0	0	0
APMA	99304	XXX	Initial NF, PD, SF or low MDM	APMA	27	0.044	0.037	0.75	1.50	1.60	1.75	2.60	43	5			10	20	30	30	48	8	0	0	0	20	1150
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and	2019-04	108	0.054	0.043			2.60			60	10					40			10					
2nd REF	99203	XXX	Office or other outpatient visit for the evaluation and	2019-04	25	0.055	0.046			1.60			35	5					25			5					
CURRENT	99305	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.055	0.041			2.35			57	11					33			13					
SVY	99305	XXX	Initial nursing facility care, per day, for the evaluation and		204	0.066	0.050	0.75	2.50	2.75	3.00	4.75	55	10			6	25	35	45	180	10	0	5	21	81	962
AMDA	99305	XXX	Initial NF, PD, moderate MDM	AMDA	125	0.055	0.044	0.95	2.35	2.66	3.00	4.00	60	10			6	30	40	45	180	10	0	5	28	100	962
AAPM&R	99305	XXX	Initial NF, PD, moderate MDM	AAPM&R	20	0.072	0.053	1.00	2.39	2.75	3.01	4.75	51.5	9			15	24	33	40	60	10	0	15	51	158	725
ACP	99305	XXX	Initial NF, PD, moderate MDM	ACP	9	0.081	0.060	1.92	2.60	2.80	2.90	3.75	47	7			10	30	30	30	50	10	0	7	20	100	520
AGS	99305	XXX	Initial NF, PD, moderate MDM	AGS	49	0.059	0.044	0.75	2.60	2.80	3.50	4.00	63	15			6	25	38	50	120	10	0	1	10	26	150
ANA	99305	XXX	Initial NF, PD, moderate MDM	ANA	1	0.023	0.023	1.60	1.60	1.60	1.60	1.60	70	10			45	45	45	45	45	15	0	0	0	0	0

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Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and	2019-04	129	0.048	0.040			3.50			88	14					59			15					
2nd REF	99496	XXX	Transitional Care Management Services with the following	2018-10	30	0.051	0.051			3.79			75						75								
CURRENT	99306	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.051	0.038			3.06			80	15					45			20					
SVY	99306	XXX	Initial nursing facility care, per day, for the evaluation and		208	0.062	0.047	1.00	3.50	3.75	4.00	5.90	80	15			9	35	50	65	340	15	0	10	50	150	1500
AMDA	99306	XXX	Initial NF, PD, High MDM	AMDA	125	0.061	0.047	1.30	3.50	3.72	4.00	5.00	80	15			9	40	50	65	340	15	0	12	57	150	1500
AAPM&R	99306	XXX	Initial NF, PD, High MDM	AAPM&R	20	0.075	0.058	1.00	3.08	3.65	3.84	5.90	62.5	10			20	30	43	53	60	10	0	10	50	193	500
ACP	99306	XXX	Initial NF, PD, High MDM	ACP	10	0.078	0.059	2.80	3.50	3.60	3.80	4.00	61	13			25	40	40	44	75	8	0	7	25	70	215
AGS	99306	XXX	Initial NF, PD, High MDM	AGS	52	0.050	0.040	1.00	3.23	3.80	4.07	5.00	95	20			10	35	60	71	120	15	0	5	40	100	432
ANA	99306	XXX	Initial NF, PD, High MDM	ANA	1	0.037	0.032	2.75	2.75	2.75	2.75	2.75	85	10			60	60	60	60	60	15	0	0	0	0	0
1st REF	99212	XXX	Office or other outpatient visit for the evaluation and	2019-04	130	0.053	0.044			0.70			16	2					11			3					
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	43	0.054	0.043			1.30			30	5					20			5					
CURRENT	99307	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.054	0.038			0.76			20	5					10			5					
SVY	99307	XXX	Subsequent nursing facility care, per day, for the evaluation and management of a patient,		196	0.063	0.057	0.18	0.70	0.80	1.30	4.00	14	1			0	10	12	15	120	1	0	0	10	49	3000
AMDA	99307	XXX	Subsequent NF, PD, SF or low MDM	AMDA	123	0.071	0.071	0.18	0.70	0.85	1.30	2.80	12	0			3	10	12	15	60	0	0	2	19	50	2000
AAPM&R	99307	XXX	Subsequent NF, PD, SF or low MDM	AAPM&R	18	0.071	0.057	0.65	0.71	0.80	1.19	1.92	14	1			5	10	10	15	35	3	0	0	4	44	689
ACP	99307	XXX	Subsequent NF, PD, SF or low MDM	ACP	9	0.042	0.039	0.60	0.70	0.70	0.80	1.40	18	2			8	10	15	15	50	1	0	3	12	24	1000
AGS	99307	XXX	Subsequent NF, PD, SF or low MDM	AGS	45	0.066	0.053	0.50	0.80	0.90	1.30	4.00	17	3			0	10	12	15	120	2	0	0	2	15	3000
ANA	99307	XXX	Subsequent NF, PD, SF or low MDM	ANA	1	0.010	0.017	0.75	0.75	0.75	0.75	0.75	45	10			20	20	20	20	20	15	0	0	0	0	0

Tab 13 NF RUC Summary

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Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	140	0.054	0.043			1.30			30	5					20			5					
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.051	0.041			1.92			47	7					30			10					
CURRENT	99308	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.053	0.037			1.16			31	7					15			9					
SVY	99308	XXX	Subsequent nursing facility care, per day, for the evaluation		214	0.069	0.053	0.50	1.30	1.44	1.85	5.00	27	5			3	15	18	25	120	4	0	20	100	350	6000
AMDA	99308	XXX	Subsequent NF, PD, Low level MDM	AMDA	129	0.065	0.054	0.70	1.30	1.40	1.92	3.60	26	3			5	15	19	25	90	4	0	33	114	400	2500
AAPM&R	99308	XXX	Subsequent NF, PD, Low level MDM	AAPM&R	23	0.084	0.067	0.70	1.20	1.40	1.50	1.98	21	3			3	10	15	18	35	3	0	18	400	1185	6000
ACP	99308	XXX	Subsequent NF, PD, Low level MDM	ACP	10	0.070	0.056	1.30	1.30	1.40	1.48	2.60	25	4			10	12	18	25	35	4	0	11	40	238	2000
AGS	99308	XXX	Subsequent NF, PD, Low level MDM	AGS	51	0.064	0.050	0.50	1.30	1.50	1.91	5.00	30	5			3	15	20	25	120	5	0	3	30	143	1000
ANA	99308	XXX	Subsequent NF, PD, Low level MDM	ANA	1	0.024	0.023	1.40	1.40	1.40	1.40	1.40	60	15			30	30	30	30	30	15	250	250	250	250	250
1st REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	149	0.051	0.041			1.92			47	7					30			10					
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	34	0.050	0.040			2.80			70	10					45			15					
CURRENT	99309	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.044	0.034			1.55			45	10					25			10					
SVY	99309	XXX	Subsequent nursing facility care, per day, for the evaluation		217	0.057	0.044	0.75	1.92	2.09	2.60	6.00	47	7			5	20	30	35	120	10	0	30	100	355	2000
AMDA	99309	XXX	Subsequent NF, PD, moderate MDM	AMDA	131	0.058	0.046	1.10	1.94	2.07	2.64	4.15	45	5			5	20	30	38	120	10	0	40	123	350	2000
AAPM&R	99309	XXX	Subsequent NF, PD, moderate MDM	AAPM&R	23	0.071	0.057	1.00	1.60	2.00	2.23	3.00	35	5			5	15	25	25	40	5	0	50	355	1000	2000
ACP	99309	XXX	Subsequent NF, PD, moderate MDM	ACP	10	0.070	0.054	1.92	1.96	2.05	2.53	2.80	38	7			15	20	25	33	40	6	0	9	24	198	750
AGS	99309	XXX	Subsequent NF, PD, moderate MDM	AGS	52	0.054	0.041	0.75	1.92	2.10	2.80	6.00	51	11			6	24	30	36	120	10	0	15	50	175	1476
ANA	99309	XXX	Subsequent NF, PD, moderate MDM	ANA	1	0.033	0.028	2.10	2.10	2.10	2.10	2.10	75	15			40	40	40	40	40	20	400	400	400	400	400
1st REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	147	0.050	0.040			2.80			70	10					45			15					
2nd REF	99291	XXX	Critical care, evaluation and management of the critically ill	2005-08	19	0.096	0.064			4.50			70	15					40			15					
CURRENT	99310	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.045	0.034			2.35			70	15					35			20					
SVY	99310	XXX	Subsequent nursing facility care, per day, for the evaluation		203	0.054	0.043	1.00	2.80	3.00	3.60	7.00	70	10			0	30	45	55	180	15	0	2	15	50	1500
AMDA	99310	XXX	Subsequent NF, PD, High MDM	AMDA	126	0.054	0.043	1.10	2.80	3.00	3.74	5.00	70	10			5	35	45	59	180	15	0	3	15	54	1500
AAPM&R	99310	XXX	Subsequent NF, PD, High MDM	AAPM&R	18	0.085	0.060	1.00	2.50	3.00	3.43	4.50	50	10			10	30	30	44	55	10	0	1	19	163	884
ACP	99310	XXX	Subsequent NF, PD, High MDM	ACP	9	0.080	0.059	2.80	2.80	3.00	3.20	4.00	51	10			20	30	32	45	60	9	0	0	3	25	45
AGS	99310	XXX	Subsequent NF, PD, High MDM	AGS	49	0.052	0.040	1.00	2.80	3.00	3.60	7.00	75	15			0	35	45	60	120	15	0	2	12	45	1200
ANA	99310	XXX	Subsequent NF, PD, High MDM	ANA	1	0.040	0.032	2.90	2.90	2.90	2.90	2.90	90	20			50	50	50	50	50	20	1500	1500	1500	1500	1500
1st REF	99495	XXX	Transitional Care Management Services with the following	2018-10	78	0.051	0.051			2.78			54						54								
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	33	0.051	0.041			1.92			47	7					30			10					
CURRENT	99315	XXX	Nursing facility discharge day management; 30 minutes or less	10/1/2010		0.042	0.032			1.28			40	10					20			10					
SVY	99315	XXX	Nursing facility discharge day management; 30 minutes or		185	0.071	0.053	0.50	1.50	2.10	2.78	8.00	40	10			0	20	25	30	125	5	0	0	10	28	450

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Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE					
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
AMDA	99315	XXX	NF Discharge Mgt 30 min or less	AMDA	124	0.069	0.051	0.70	1.50	2.05	2.78	4.50	40	10			0	17	25	30	60	5	0	1	10	25	450
AAPM&R	99315	XXX	NF Discharge Mgt 30 min or less	AAPM&R	10	0.081	0.056	1.00	1.41	1.96	2.21	2.78	35	8			0	13	20	29	30	8	0	0	0	13	75
ACP	99315	XXX	NF Discharge Mgt 30 min or less	ACP	8	0.071	0.059	0.93	3.00	1.95	2.78	3.00	33	5			15	19	25	26	40	3	0	4	24	73	210
AGS	99315	XXX	NF Discharge Mgt 30 min or less	AGS	42	0.071	0.054	0.50	1.93	2.52	3.00	8.00	47	12			10	20	30	34	125	5	0	0	2	30	300
ANA	99315	XXX	NF Discharge Mgt 30 min or less	ANA	1	0.111	0.058	2.90	2.90	2.90	2.90	2.90	50	30			20	20	20	20	20	0	0	0	0	0	0
1st REF	99496	XXX	Transitional Care Management Services with the following	2018-10	88	0.051	0.051			3.79			75						75									
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.050	0.040			2.80			70	10					45			15					
CURRENT	99316	XXX	Nursing facility discharge day management; more than 30 minutes	10/1/2010		0.050	0.035			1.90			54	14					25			15					
SVY	99316	XXX	Nursing facility discharge day management; more than 30		191	0.062	0.048	0.75	2.50	3.01	3.80	9.00	63	15			0	30	40	50	120	8	0	0	10	40	800
AMDA	99316	XXX	NF Discharge Mgt 30 min or more	AMDA	125	0.064	0.050	1.00	2.48	3.00	3.79	4.80	60	12			0	30	40	50	90	8	0	1	10	45	800
AAPM&R	99316	XXX	NF Discharge Mgt 30 min or more	AAPM&R	10	0.068	0.049	1.50	2.00	2.65	2.96	4.50	54	13			0	21	32	43	60	10	0	0	0	11	75
ACP	99316	XXX	NF Discharge Mgt 30 min or more	ACP	10	0.070	0.054	1.60	2.19	3.30	3.83	4.50	61.5	14			22	35	40	48	50	8	0	1	8	34	200
AGS	99316	XXX	NF Discharge Mgt 30 min or more	AGS	45	0.065	0.049	0.75	2.95	3.50	3.99	9.00	71	16			10	35	45	55	120	10	0	0	9	37	300
ANA	99316	XXX	NF Discharge Mgt 30 min or more	ANA	1	0.089	0.044	4.00	4.00	4.00	4.00	4.00	90	60			30	30	30	30	30	0	30	30	30	30	30
	99318	XXX	Evaluation and management of a patient involving an annual nursing	2007-02	CODE will be deleted	0.047	0.036			1.71			47	10					27			10					

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ISSUE: Nursing Facility (*Medical Specialty Details*)

TAB: 13 AAPM&R, ACP, AGS, AMDA, ANA, APMA

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	86	0.055	0.046			1.60			35	5					25			5					
2nd REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new	2019-04	46	0.055	0.047			0.93			20	2					15			3					
CURRENT	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.052	0.038			1.64			43	10					23			10					
SVY	99304	XXX	Initial nursing facility care, per day, for the evaluation and management of a		203	0.058	0.047	0.50	1.50	1.70	2.00	30.00	36	6			0	20	25	30	120	5	0	0	2	12	1150
Geriatric Medicine & Hospice and Paliative Medicine	99304	XXX	Initial NF, PD, SF or low MDM	Geriatric Medicine & Hospice and Paliative Medicine	97	0.051	0.043	0.50	1.60	1.80	2.15	4.00	42	7			3	20	30	35	120	5	0	0	2	10	150
IM & FM	99304	XXX	Initial NF, PD, SF or low MDM	IM & FM	59	0.054	0.043	0.70	1.21	1.64	2.00	3.25	38	8			0	15	25	30	120	5	0	0	5	20	750
NP & PA	99304	XXX	Initial NF, PD, SF or low MDM	NP & PA	3	0.012	0.017	0.93	0.93	0.93	15.47	30.00	55	20			5	18	30	38	45	5	0	10	20	160	300
Other, Ped and	99304	XXX	Initial NF, PD, SF or low MDM	Other, Ped and	2	0.046	0.036	1.50	1.53	1.55	1.58	1.60	42.5	10			25	25	25	25	25	8	6	30	53	77	100
PM&R	99304	XXX	Initial NF, PD, SF or low MDM	PM&R	16	0.069	0.058	0.93	1.60	1.90	2.53	3.50	32.5	4			7	20	25	30	60	4	0	0	0	13	75
Podiatry	99304	XXX	Initial NF, PD, SF or low MDM	Podiatry	26	0.044	0.038	0.75	1.50	1.60	1.78	2.60	42	5			10	20	30	30	48	7	0	0	0	19	1150
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and	2019-04	108	0.054	0.043			2.60			60	10					40			10					
2nd REF	99203	XXX	Office or other outpatient visit for the evaluation and	2019-04	25	0.055	0.046			1.60			35	5					25			5					
CURRENT	99305	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.055	0.041			2.35			57	11					33			13					
SVY	99305	XXX	Initial nursing facility care, per day, for the evaluation and		204	0.066	0.050	0.75	2.50	2.75	3.00	4.75	55	10			6	25	35	45	180	10	0	5	21	81	962
Geriatric Medicine & Hospice and Paliative Medicine	99305	XXX	Initial NF, PD, moderate MDM	Geriatric Medicine & Hospice and Paliative Medicine	109	0.058	0.046	0.75	2.60	2.80	3.00	4.00	61	11			6	30	40	52	120	10	0	5	15	50	962
IM & FM	99305	XXX	Initial NF, PD, moderate MDM	IM & FM	71	0.063	0.048	1.00	1.92	2.65	2.93	4.00	55	10			10	25	35	45	180	10	0	4	40	100	600
NP & PA	99305	XXX	Initial NF, PD, moderate MDM	NP & PA	2	0.054	0.038	1.60	1.85	2.10	2.35	2.60	55	18			10	19	28	36	45	10	0	38	75	113	150
Other, Ped and	99305	XXX	Initial NF, PD, moderate MDM	Other, Ped and	1	0.053	0.046	2.43	2.43	2.43	2.43	2.43	53	3			40	40	40	40	40	10	6	6	6	6	6
PM&R	99305	XXX	Initial NF, PD, moderate MDM	PM&R	21	0.080	0.061	1.00	2.35	2.75	3.00	4.75	45	8			10	20	30	40	60	7	0	15	48	150	725

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Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and	2019-04	129	0.048	0.040			3.50			88	14					59			15					
2nd REF	99496	XXX	Transitional Care Management Services with the following	2018-10	30	0.051	0.051			3.79			75						75								
CURRENT	99306	XXX	Initial nursing facility care, per day, for the evaluation and management of a	2/1/2007		0.051	0.038			3.06			80	15					45			20					
SVY	99306	XXX	Initial nursing facility care, per day, for the evaluation and		208	0.062	0.047	1.00	3.50	3.75	4.00	5.90	80	15			9	35	50	65	340	15	0	10	50	150	1500
Geriatric Medicine & Hospice and Paliative Medicine	99306	XXX	Initial NF, PD, High MDM	Geriatric Medicine & Hospice and Paliative Medicine	113	0.056	0.044	1.00	3.50	3.75	4.00	5.00	85	15			9	40	55	75	150	15	0	10	48	100	600
IM & FM	99306	XXX	Initial NF, PD, High MDM	IM & FM	71	0.069	0.051	1.50	3.13	3.75	4.00	5.00	74	14			15	35	45	60	340	15	0	10	58	200	1500
NP & PA	99306	XXX	Initial NF, PD, High MDM	NP & PA	2	0.074	0.050	3.50	3.50	3.50	3.50	3.50	70	25			15	26	38	49	60	8	0	38	75	113	150
Other, Ped and	99306	XXX	Initial NF, PD, High MDM	Other, Ped and	1	0.050	0.047	3.17	3.17	3.17	3.17	3.17	68	3			60	60	60	60	60	5	12	12	12	12	12
PM&R	99306	XXX	Initial NF, PD, High MDM	PM&R	21	0.079	0.060	1.00	3.10	3.60	3.79	5.90	60	10			15	30	40	50	60	10	0	0	50	191	500
1st REF	99212	XXX	Office or other outpatient visit for the evaluation and	2019-04	130	0.053	0.044			0.70			16	2					11			3					
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	43	0.054	0.043			1.30			30	5					20			5					
CURRENT	99307	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.054	0.038			0.76			20	5					10			5					
SVY	99307	XXX	Subsequent nursing facility care, per day, for the evaluation and management of a patient,		196	0.063	0.057	0.18	0.70	0.80	1.30	4.00	14	1			0	10	12	15	120	1	0	0	10	49	3000
Geriatric Medicine & Hospice and Paliative Medicine	99307	XXX	Subsequent NF, PD, SF or low MDM	Geriatric Medicine & Hospice and Paliative Medicine	103	0.065	0.062	0.50	0.70	0.80	1.30	4.00	13	1			0	10	12	15	120	0	0	0	10	30	3000
IM & FM	99307	XXX	Subsequent NF, PD, SF or low MDM	IM & FM	70	0.054	0.049	0.18	0.70	0.88	1.30	2.80	18	1			0	10	15	17	60	2	0	2	20	60	2000
NP & PA	99307	XXX	Subsequent NF, PD, SF or low MDM	NP & PA	3	0.051	0.034	0.70	0.78	0.85	1.07	1.29	25	10			5	8	10	13	15	5	0	3	5	15	25
Other, Ped and	99307	XXX	Subsequent NF, PD, SF or low MDM	Other, Ped and	1	0.096	0.096	0.48	0.48	0.48	0.48	0.48	5	0			5	5	5	5	5	0	25	25	25	25	25
PM&R	99307	XXX	Subsequent NF, PD, SF or low MDM	PM&R	19	0.073	0.062	0.65	0.73	0.80	1.18	1.92	13	1			4	9	10	15	35	2	0	0	3	38	689

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Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019-04	140	0.054	0.043			1.30			30	5					20			5					
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.051	0.041			1.92			47	7					30			10					
CURRENT	99308	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.053	0.037			1.16			31	7					15			9					
SVY	99308	XXX	Subsequent nursing facility care, per day, for the evaluation		214	0.069	0.053	0.50	1.30	1.44	1.85	5.00	27	5			3	15	18	25	120	4	0	20	100	350	6000
Geriatric Medicine & Hospice and Paliative Medicine	99308	XXX	Subsequent NF, PD, Low level MDM	Geriatric Medicine & Hospice and Paliative Medicine	112	0.061	0.048	0.50	1.30	1.41	1.87	5.00	29.5	5			3	15	20	25	120	5	0	11	60	200	2000
IM & FM	99308	XXX	Subsequent NF, PD, Low level MDM	IM & FM	74	0.064	0.053	0.70	1.30	1.45	1.92	2.75	27.5	4			5	15	20	25	90	4	0	40	200	500	2500
NP & PA	99308	XXX	Subsequent NF, PD, Low level MDM	NP & PA	5	0.124	0.082	0.93	1.30	1.40	1.50	2.05	17	3			3	10	10	14	20	4	180	300	750	791	5000
Other, Ped and	99308	XXX	Subsequent NF, PD, Low level MDM	Other, Ped and	1	0.088	0.069	0.97	0.97	0.97	0.97	0.97	14	2			10	10	10	10	10	2	100	100	100	100	100
PM&R	99308	XXX	Subsequent NF, PD, Low level MDM	PM&R	22	0.085	0.066	0.70	1.21	1.43	1.50	1.98	21.5	4			7	10	15	19	35	3	0	6	350	815	6000
1st REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	149	0.051	0.041			1.92			47	7					30			10					
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	34	0.050	0.040			2.80			70	10					45			15					
CURRENT	99309	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.044	0.034			1.55			45	10					25			10					
SVY	99309	XXX	Subsequent nursing facility care, per day, for the evaluation		217	0.057	0.044	0.75	1.92	2.09	2.60	6.00	47	7			5	20	30	35	120	10	0	30	100	355	2000
Geriatric Medicine & Hospice and Paliative Medicine	99309	XXX	Subsequent NF, PD, moderate MDM	Geriatric Medicine & Hospice and Paliative Medicine	114	0.056	0.043	0.75	1.95	2.10	2.80	6.00	49	9			6	24	30	40	120	10	0	20	78	300	2000
IM & FM	99309	XXX	Subsequent NF, PD, moderate MDM	IM & FM	75	0.063	0.049	1.10	1.92	2.10	2.59	3.60	43	5			5	20	28	37	120	10	0	55	156	350	2000
NP & PA	99309	XXX	Subsequent NF, PD, moderate MDM	NP & PA	5	0.097	0.051	1.60	1.92	2.02	2.20	2.67	40	15			5	10	15	25	30	10	48	400	1513	1560	1700
Other, Ped and	99309	XXX	Subsequent NF, PD, moderate MDM	Other, Ped and	1	0.076	0.063	1.25	1.25	1.25	1.25	1.25	20	3			15	15	15	15	15	2	60	60	60	60	60
PM&R	99309	XXX	Subsequent NF, PD, moderate MDM	PM&R	22	0.071	0.057	1.00	1.63	2.00	2.25	3.00	35	5			9	15	25	25	40	5	0	50	180	768	2000
1st REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	147	0.050	0.040			2.80			70	10					45			15					
2nd REF	99291	XXX	Critical care, evaluation and management of the critically ill	2005-08	19	0.096	0.064			4.50			70	15					40			15					
CURRENT	99310	XXX	Subsequent nursing facility care, per day, for the evaluation and	2/1/2007		0.045	0.034			2.35			70	15					35			20					
SVY	99310	XXX	Subsequent nursing facility care, per day, for the evaluation		203	0.054	0.043	1.00	2.80	3.00	3.60	7.00	70	10			0	30	45	55	180	15	0	2	15	50	1500
Geriatric Medicine & Hospice and Paliative Medicine	99310	XXX	Subsequent NF, PD, High MDM	Geriatric Medicine & Hospice and Paliative Medicine	109	0.054	0.043	1.00	2.80	3.00	3.60	7.00	70	10			10	35	45	60	120	15	0	3	15	48	1200
IM & FM	99310	XXX	Subsequent NF, PD, High MDM	IM & FM	71	0.057	0.045	1.10	2.80	3.00	3.50	4.87	66	9			0	30	44	50	180	13	0	2	14	60	1500
NP & PA	99310	XXX	Subsequent NF, PD, High MDM	NP & PA	5	0.075	0.049	2.80	2.80	2.90	3.50	3.95	59	15			10	15	30	30	55	14	6	25	150	533	884
Other, Ped and	99310	XXX	Subsequent NF, PD, High MDM	Other, Ped and	1	0.071	0.057	2.00	2.00	2.00	2.00	2.00	35	5			25	25	25	25	25	5	12	12	12	12	12
PM&R	99310	XXX	Subsequent NF, PD, High MDM	PM&R	17	0.073	0.055	1.00	2.40	3.00	3.92	5.00	55	10			18	30	35	45	55	10	0	0	5	30	500

Tab 13 NF RUC Summary

Updated: 5/24/20224:54 PM

Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
								MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
1st REF	99495	XXX	Transitional Care Management Services with the following	2018-10	78	0.051	0.051			2.78			54						54									
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019-04	33	0.051	0.041			1.92			47	7					30			10					
CURRENT	99315	XXX	Nursing facility discharge day management; 30 minutes or less	10/1/2010		0.042	0.032			1.28			40	10					20			10					
SVY	99315	XXX	Nursing facility discharge day management; 30 minutes or		185	0.071	0.053	0.50	1.50	2.10	2.78	8.00	40	10			0	20	25	30	125	5	0	0	10	28	450
Geriatric Medicine & Hospice and Paliative	99315	XXX	NF Discharge Mgt 30 min or less	Geriatric Medicine & Hospice and Paliative	101	0.080	0.060	0.50	1.80	2.50	2.80	8.00	42	10			5	20	27	30	120	5	0	0	6	22	300
IM & FM	99315	XXX	NF Discharge Mgt 30 min or less	IM & FM	69	0.071	0.057	0.93	1.50	2.00	2.78	3.80	35	10			0	20	25	30	125	0	0	1	10	50	300
NP & PA	99315	XXX	NF Discharge Mgt 30 min or less	NP & PA	3	0.158	0.077	1.40	3.00	1.92	2.27	2.61	25	10			10	10	10	13	15	5	2	14	25	238	450
Other, Ped and	99315	XXX	NF Discharge Mgt 30 min or less	Other, Ped and	1	0.053	0.050	1.50	1.50	1.50	1.50	1.50	30	3			27	27	27	27	27	0	6	6	6	6	6
PM&R	99315	XXX	NF Discharge Mgt 30 min or less	PM&R	11	0.078	0.050	1.00	1.53	2.00	2.43	3.50	40	10			0	15	20	28	30	10	0	0	0	10	75
1st REF	99496	XXX	Transitional Care Management Services with the following	2018-10	88	0.051	0.051			3.79			75						75									
2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019-04	38	0.050	0.040			2.80			70	10					45			15					
CURRENT	99316	XXX	Nursing facility discharge day management; more than 30 minutes	10/1/2010		0.050	0.035			1.90			54	14					25			15					
SVY	99316	XXX	Nursing facility discharge day management; more than 30		191	0.062	0.048	0.75	2.50	3.01	3.80	9.00	63	15			0	30	40	50	120	8	0	0	10	40	800
Geriatric Medicine & Hospice and Paliative Medicine	99316	XXX	NF Discharge Mgt 30 min or more	Geriatric Medicine & Hospice and Paliative Medicine	107	0.065	0.050	0.75	2.69	3.50	3.83	9.00	70	15			10	34	45	55	120	10	0	0	10	40	400
IM & FM	99316	XXX	NF Discharge Mgt 30 min or more	IM & FM	69	0.067	0.055	1.00	2.35	3.00	3.79	4.80	55	12			0	30	40	45	90	3	0	0	5	40	300
NP & PA	99316	XXX	NF Discharge Mgt 30 min or more	NP & PA	3	0.245	0.097	2.80	2.85	2.90	3.40	3.90	30	15			10	10	10	20	30	5	72	236	400	600	800
Other, Ped and	99316	XXX	NF Discharge Mgt 30 min or more	Other, Ped and	1	0.045	0.044	2.11	2.11	2.11	2.11	2.11	48	3			45	45	45	45	45	0	0	0	0	0	0
PM&R	99316	XXX	NF Discharge Mgt 30 min or more	PM&R	11	0.078	0.056	1.50	2.00	2.80	3.26	4.50	50	10			0	23	30	40	60	10	0	0	0	8	75
	99318	XXX	Evaluation and management of a patient involving an annual nursing	2007-02	CODE will be deleted	0.047	0.036			1.71			47	10					27			10					

FACILITY DIRECT PE INPUTS **CPT CODE(S):99304-99310**

SPECIALTY SOCIETY(IES):_AAPM&R, ACP, AGS, AMDA, ANA, APMA

PRESENTER(S): Brooke Bisbee, DPM; Charles Crecelius, MD, PhD, CMD; Audrey Chun, MD; and Carlo Milani, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April, 2021

CPT Code	Long Descriptor	Global Period
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded. (For services ZZ minutes or longer, use prolonged services code 993X0)	XXX
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded. (For services ZZ minutes or longer, use prolonged services code 993X0)	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99304	Initial nursing facility visit for a patient with limited supports at home receiving post-acute care for an operative procedure that was uncomplicated.
99305	Initial nursing facility visit for a patient with recovering from an illness or acute injury that requires ongoing medical management of their multiple stable problems.
99306	Initial nursing facility visit for patient with multiple morbidities requiring intensive management
99307	Subsequent nursing facility visit for a patient with a self-limited or minor problem

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

99308	Subsequent nursing facility visit for a patient with a stable chronic illness or recovering from an acute uncomplicated injury.
99309	Subsequent nursing facility visit for a patient with a new or progressing illness or acute injury that requires diagnostic evaluation, medical management, or potential surgical treatment.
99310	Subsequent nursing facility visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The specialty society expert panel, comprised of advisors from the participating specialties, met and discussed recommendations for practice expense both via phone and over email. The expert panel reviewed the existing PE inputs for the code family and made revisions as necessary to reflect current practice.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing PE inputs from 2005 (99304-99310) were used as reference.

3. Is this code(s) typically reported with an E/M service?

   No

4. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

   N/A

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

   N/A

6. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

   Pre-Service
   All codes include time for an activity described in 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA005 Complete pre-procedure phone calls and prescription.
   Several codes, specifically 99308, 99309 and 99310, include time for an activity described in the 2005 PE spreadsheets a "review/read x-ray, lab and pathology reports." This has been rolled into CA006 Confirm availability of prior images/studies.

Post-Service
All codes include time for an activity described in 2004 and 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA037 Conduct patient communications.
Codes 99304-99310 included time for an activity described in the 2005 PE spreadsheet as "review/read x-ray, lab, and pathology reports" as well as "respond to consultant pharmacist or nutritionist reviews and recommendations" and "monitoring patient/notifying physician of change in condition" which have all be rolled into CA038 Coordinate post-procedure services.

7. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

99304	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99305	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99306	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99307	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit.
99308	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit. **CA006 3 minutes** Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.
99309	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit. **CA006 3 minutes** Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.
99310	**CA005 6 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit.

	CA006 3 minutes Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.

b. Service period (includes pre, intra and post):

c. Post-service period:

99304	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99305	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99306	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99307	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99308	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.

99309	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99310	**CA037 6 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.

8. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

9. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

10. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

11. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

12. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

13. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A

14. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if

available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A

15. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

N/A

16. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

17. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

18. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

19. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

FACILITY DIRECT PE INPUTS **CPT CODE(S):99304-99310**

SPECIALTY SOCIETY(IES):_AAPM&R, ACP, AGS, AMDA, ANA, APMA

PRESENTER(S): Brooke Bisbee, DPM; Charles Crecelius, MD, PhD, CMD; Audrey Chun, MD; and Carlo Milani, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

NON-FACILITY DIRECT PE INPUTS **CPT CODE(S):__99304-99310**

SPECIALTY SOCIETY(IES):_AAPM&R, ACP, AGS, AMDA, ANA, APMA_

PRESENTER(S): Brooke Bisbee, DPM; Charles Crecelius, MD, PhD, CMD; Audrey Chun, MD; and Carlo Milani, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: April, 2021

CPT Code	Long Descriptor	Global Period
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded.	XXX
99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, XX minutes must be met or exceeded. (For services ZZ minutes or longer, use prolonged services code 993X0)	XXX
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded.	XXX
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of encounter for code selection, XX minutes must be met or exceeded. (For services ZZ minutes or longer, use prolonged services code 993X0)	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
99304	Initial nursing facility visit for a patient with limited supports at home receiving post-acute care for an operative procedure that was uncomplicated.
99305	Initial nursing facility visit for a patient with recovering from an illness or acute injury that requires ongoing medical management of their multiple stable problems.
99306	Initial nursing facility visit for patient with multiple morbidities requiring intensive management
99307	Subsequent nursing facility visit for a patient with a self-limited or minor problem

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

99308	Subsequent nursing facility visit for a patient with a stable chronic illness or recovering from an acute uncomplicated injury.
99309	Subsequent nursing facility visit for a patient with a new or progressing illness or acute injury that requires diagnostic evaluation, medical management, or potential surgical treatment.
99310	Subsequent nursing facility visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The specialty society expert panel, comprised of advisors from the participating specialties, met and discussed recommendations for practice expense both via phone and over email. The expert panel reviewed the existing PE inputs for the code family and made revisions as necessary to reflect current practice.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Existing PE inputs from 2005 (99304-99310) were used as reference.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   No

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

   Non-Facility Dominant Specialties

99304	Non-Facility Dominant Specialties – podiatry (31.4%), family medicine (17%) and nurse practitioner (13.5%)
99305	Non-Facility Dominant Specialties – internal medicine (23.6%), nurse practitioner (22.6%), family medicine (19.2%)
99306	Non-Facility Dominant Specialties – internal medicine (38.9%), family medicine (19.1%) and nurse practitioner (17.2%)
99307	Non-Facility Dominant Specialties – podiatry (22.4%), nurse practitioner (20.9%), family medicine (19.1%), internal medicine (17.4%)
99308	Non-Facility Dominant Specialties – nurse practitioner (41.5%), internal medicine (19.1%), family medicine (15.5%)

99309	Non-Facility Dominant Specialties – nurse practitioner (48.4%), internal medicine (18.8%), family medicine (14%)
99310	Non-Facility Dominant Specialties – nurse practitioner (49.5%), internal medicine (17.3%), family medicine (12.9%)

There are small differences in the percentages and order of the dominant specialties when comparing non-facility to global dominant specialties.

Global Dominant Specialties

99304	Non-Facility Dominant Specialties – podiatry (22.8%), family medicine (18.4%) and internal medicine (12.5%)
99305	Non-Facility Dominant Specialties – internal medicine (29.8%), family medicine (19.3%), nurse practitioner (13.8%)
99306	Non-Facility Dominant Specialties – internal medicine (42.6%), family medicine (19.5%) and nurse practitioner (9.8%)
99307	Non-Facility Dominant Specialties –nurse practitioner (24.8%), family medicine (19.1%), internal medicine (17.4%)
99308	Non-Facility Dominant Specialties – nurse practitioner (37.5%), internal medicine (22.1%), family medicine (13%)
99309	Non-Facility Dominant Specialties – nurse practitioner (45.3%), internal medicine (21.6%), family medicine (12%)
99310	Non-Facility Dominant Specialties – nurse practitioner (50.2%), internal medicine (18.8%), family medicine (10.6%)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

N/A

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

Pre-Service All codes include time for an activity described in 2004 and 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA005 Complete pre-procedure phone calls and prescription. Several codes, specifically 99308, 99309 and 99310, include time for an activity described in the 2005 PE spreadsheets a "review/read x-ray, lab and pathology reports." This has been rolled into CA006 Confirm availability of prior images/studies.

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Post-Service
All codes include time for an activity described in 2004 and 2005 PE spreadsheets as "phone calls between visits with patient, family, pharmacy." This has been rolled into CA037 Conduct patient communications.
Codes 99304-99310 included time for an activity described in the 2005 PE spreadsheet as "review/read x-ray, lab, and pathology reports" as well as "respond to consultant pharmacist or nutritionist reviews and recommendations" and "monitoring patient/notifying physician of change in condition" which have all be rolled into CA038 Coordinate post-procedure services.

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

99304	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99305	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99306	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver and confirms medications. Relevant data is transferred from facility EMR to provider EMR.
99307	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit.
99308	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit. **CA006 3 minutes** Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.
99309	**CA005 3 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit. **CA006 3 minutes**

	Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.
99310	**CA005 6 minutes** Clinical staff completes phone calls with family/caregiver or nurse/care coordinator at the facility, confirms any procedures or services provided since last visit, and confirms medication changes since last visit. **CA006 3 minutes** Clinical staff confirms availability of any imaging completed since the last visit as well as any reports related to services or procedures provided.

b. Service period (includes pre, intra and post):

c. Post-service period:

99304	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99305	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99306	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99307	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99308	**CA037 3 minutes**

	Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99309	**CA037 3 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.
99310	**CA037 6 minutes** Clinical staff completes follow-up phone calls with family/caregiver and/or facility nurse/therapist/care coordinator. **CA038 8 minutes** Staff confirms new procedure/therapy/DME orders and medication updates/prior authorizations are directed correctly. Staff assists in coordination of care between providers. Staff assists in interfacing between documentation in facility EMR and physician EMR.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

N/A

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:
    N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
    N/A

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.
    N/A

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:
    N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?
    N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:
    N/A

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:
    N/A

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**CPT Code 99304**		**CPT Code 99304**		**CPT Code 99305**	
3		***RUC Collaboration Website***				Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**14.0**	**14.0**	**14.0**	**14.0**	**14.0**	**14.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**11.0**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**									
14		**Start: Following visit when decision for surgery/procedure made**									
15	CA001		L037D								
16	CA002		L037D								
17	CA003		L037D								
18	CA004		L037D								
19	CA005		L037D			3	3	3	3	3	3
20	CA006		L037D								
21	CA007		L037D								
22	CA008		L037D								
23			L037D								
26		*Other activity: please include short clinical description here and type*	L037D								
29		**End: When patient enters office/facility for surgery/procedure**									
30		**SERVICE PERIOD**									
31		**Start: When patient enters office/facility for surgery/procedure:**									
32		**Pre-Service (of service period)**									
33	CA009		L037D								
34	CA010		L037D								
35	CA011		L037D								
36	CA012		L037D								
37	CA013		L037D								
38	CA014		L037D								
39	CA015		L037D								
40	CA016		L037D								
41	CA017		L037D								
42			L037D								
45		*Other activity: please include short clinical description here and type*	L037D								
48		**Intra-service (of service period)**									
49	CA018		L037D								
50	CA019		L037D								
51	CA020		L037D								
52	CA021		L037D								
55			L037D								
56		*Other activity: please include short clinical description here and type*	L037D								
59		**Post-Service (of service period)**									
60	CA022		L037D								
61	CA023		L037D								
62	CA024		L037D								
63	CA025		L037D								
64	CA026		L037D								
65	CA027		L037D								
66	CA028		L037D								
67	CA029		L037D								
68	CA030		L037D								
69	CA031		L037D								
70	CA032		L037D								
71	CA033		L037D								
72	CA034		L037D								
73	CA035		L037D								
74	CA036		L037D			**n/a**		**n/a**		**n/a**	
75			L037D								
78		*Other activity: please include short clinical description here and type*	L037D								
81		**End: Patient leaves office/facility**									
82		**POST-SERVICE PERIOD**									
83		**Start: Patient leaves office/facility**									
84	CA037		L037D			3	3	3	3	3	3
85	CA038		L037D			8	8	8	8	8	8
86		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes	16								
88		99212 27 minutes	27								
89		99213 36 minutes	36								
90		99214 53 minutes	53								
91		99215 63 minutes	63								
92	CA039		L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93			L037D								
96		*Other activity: please include short clinical description here and type*	L037D								
99		**End: with last office visit before end of global period**									

	A	B	D	E	F	I	J	K	L	M	N
1	**RUC Practice Expense Spreadsheet**					**CURRENT**		**RECOMMENDED**		**CURRENT**	
2						**CPT Code 99304**		**CPT Code 99304**		**CPT Code 99305**	
3		***RUC Collaboration Website***				Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**						
5		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	L037D			**14.0**	**14.0**	**14.0**	**14.0**	**14.0**	**14.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**11.0**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**
100	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102											
103											
104											
105											
106											
107											
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*									
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112											
113											
114											
115											
116											
117											
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*									

	A	B	O	P	Q	R	S	T	U	V	W	X
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2			**CPT Code 99305**		**CPT Code 99306**		**CPT Code 99306**		**CPT Code 99307**		**CPT Code 99307**	
3		***RUC Collaboration Website***	Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**14.0**	**14.0**	**14.0**	**14.0**	**14.0**	**14.0**	**11.0**	**11.0**	**11.0**	**11.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**	**11.0**	**8.0**	**8.0**	**8.0**	**8.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001											
16	CA002											
17	CA003											
18	CA004											
19	CA005		3	3	3	3	3	3	3	3	3	3
20	CA006											
21	CA007											
22	CA008											
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009											
34	CA010											
35	CA011											
36	CA012											
37	CA013											
38	CA014											
39	CA015											
40	CA016											
41	CA017											
42												
45		*Other activity: please include short clinical description here and type*										
48		**Intra-service (of service period)**										
49	CA018											
50	CA019											
51	CA020											
52	CA021											
55												
56		*Other activity: please include short clinical description here and type*										
59		**Post-Service (of service period)**										
60	CA022											
61	CA023											
62	CA024											
63	CA025											
64	CA026											
65	CA027											
66	CA028											
67	CA029											
68	CA030											
69	CA031											
70	CA032											
71	CA033											
72	CA034											
73	CA035											
74	CA036		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
75												
78		*Other activity: please include short clinical description here and type*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037		3	3	3	3	3	3	3	3	3	3
85	CA038		8	8	8	8	8	8	5	5	5	5
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93												
96		*Other activity: please include short clinical description here and type*										
99		**End: with last office visit before end of global period**										

	A	B	O	P	Q	R	S	T	U	V	W	X
1	RUC Practice Expense Spreadsheet		RECOMMENDED		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2			CPT Code 99305		CPT Code 99306		CPT Code 99306		CPT Code 99307		CPT Code 99307	
3		*RUC Collaboration Website*	Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Initial nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which	
4	Clinical Activity Code	Meeting Date: April 21, 2021 Revision Date (if applicable): Tab: 13 Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA										
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		TOTAL CLINICAL STAFF TIME	14.0	14.0	14.0	14.0	14.0	14.0	11.0	11.0	11.0	11.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0	3.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	11.0	11.0	11.0	11.0	11.0	11.0	8.0	8.0	8.0	8.0
100	Supply Code	MEDICAL SUPPLIES										
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
102												
103												
104												
105												
106												
107												
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
110	Equipment Code	EQUIPMENT										
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
112												
113												
114												
115												
116												
117												
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**	
2			**CPT Code 99308**		**CPT Code 99308**		**CPT Code 99309**		**CPT Code 99309**		**CPT Code 99310**	
3		***RUC Collaboration Website***	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**17.0**	**17.0**	**17.0**	**17.0**	**21.0**	**21.0**	**21.0**	**21.0**	**27.0**	**27.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**9.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**11.0**	**11.0**	**11.0**	**11.0**	**15.0**	**15.0**	**15.0**	**15.0**	**18.0**	**18.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001											
16	CA002											
17	CA003											
18	CA004											
19	CA005		3	3	3	3	3	3	3	3	6	6
20	CA006		3	3	3	3	3	3	3	3	3	3
21	CA007											
22	CA008											
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009											
34	CA010											
35	CA011											
36	CA012											
37	CA013											
38	CA014											
39	CA015											
40	CA016											
41	CA017											
42												
45		*Other activity: please include short clinical description here and type*										
48		**Intra-service (of service period)**										
49	CA018											
50	CA019											
51	CA020											
52	CA021											
55												
56		*Other activity: please include short clinical description here and type*										
59		**Post-Service (of service period)**										
60	CA022											
61	CA023											
62	CA024											
63	CA025											
64	CA026											
65	CA027											
66	CA028											
67	CA029											
68	CA030											
69	CA031											
70	CA032											
71	CA033											
72	CA034											
73	CA035											
74	CA036		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
75												
78		*Other activity: please include short clinical description here and type*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037		3	3	3	3	3	3	3	3	6	6
85	CA038		8	8	8	8	12	12	12	12	12	12
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93												
96		*Other activity: please include short clinical description here and type*										
99		**End: with last office visit before end of global period**										

	A	B	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH
1	**RUC Practice Expense Spreadsheet**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**	
2			**CPT Code 99308**		**CPT Code 99308**		**CPT Code 99309**		**CPT Code 99309**		**CPT Code 99310**	
3		***RUC Collaboration Website***	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Subsequent nursing facility care, per day, for the evaluation and management of a patient, which	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**17.0**	**17.0**	**17.0**	**17.0**	**21.0**	**21.0**	**21.0**	**21.0**	**27.0**	**27.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**6.0**	**9.0**	**9.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**11.0**	**11.0**	**11.0**	**11.0**	**15.0**	**15.0**	**15.0**	**15.0**	**18.0**	**18.0**
100	**Supply Code**	**MEDICAL SUPPLIES**										
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102												
103												
104												
105												
106												
107												
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
110	**Equipment Code**	**EQUIPMENT**										
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112												
113												
114												
115												
116												
117												
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2			**CPT Code 99310**		**CPT Code 99315**		**CPT Code 99315**		**CPT Code 99316**		**CPT Code 99316**	
3		***RUC Collaboration Website***	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Nursing facility discharge day management; 30 minutes or less		Nursing facility discharge day management; 30 minutes or less		Nursing facility discharge day management; more than 30 minutes		Nursing facility discharge day mangement; more than 30 minutes	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**27.0**	**27.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**9.0**	**9.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**18.0**	**18.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**										
14		**Start: Following visit when decision for surgery/procedure made**										
15	CA001											
16	CA002											
17	CA003											
18	CA004											
19	CA005		6	6	3	3	3	3	3	3	3	3
20	CA006		3	3								
21	CA007											
22	CA008											
23												
26		*Other activity: please include short clinical description here and type*										
29		**End: When patient enters office/facility for surgery/procedure**										
30		**SERVICE PERIOD**										
31		**Start: When patient enters office/facility for surgery/procedure:**										
32		**Pre-Service (of service period)**										
33	CA009											
34	CA010											
35	CA011											
36	CA012											
37	CA013											
38	CA014											
39	CA015											
40	CA016											
41	CA017											
42												
45		*Other activity: please include short clinical description here and type*										
48		**Intra-service (of service period)**										
49	CA018											
50	CA019											
51	CA020											
52	CA021											
55												
56		*Other activity: please include short clinical description here and type*										
59		**Post-Service (of service period)**										
60	CA022											
61	CA023											
62	CA024											
63	CA025											
64	CA026											
65	CA027											
66	CA028											
67	CA029											
68	CA030											
69	CA031											
70	CA032											
71	CA033											
72	CA034											
73	CA035											
74	CA036		**n/a**		**n/a**		**n/a**		**n/a**		**n/a**	
75												
78		*Other activity: please include short clinical description here and type*										
81		**End: Patient leaves office/facility**										
82		**POST-SERVICE PERIOD**										
83		**Start: Patient leaves office/facility**										
84	CA037		6	6	3	3	3	3	3	3	3	3
85	CA038		12	12	6	6	6	6	6	6	6	6
86		***Office visits: List Number and Level of Office Visits***	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
87		99211 16 minutes										
88		99212 27 minutes										
89		99213 36 minutes										
90		99214 53 minutes										
91		99215 63 minutes										
92	CA039		**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
93												
96		*Other activity: please include short clinical description here and type*										
99		**End: with last office visit before end of global period**										

	A	B	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**		**CURRENT**		**RECOMMENDED**	
2			**CPT Code 99310**		**CPT Code 99315**		**CPT Code 99315**		**CPT Code 99316**		**CPT Code 99316**	
3		***RUC Collaboration Website***	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which		Nursing facility discharge day management; 30 minutes or less		Nursing facility discharge day management; 30 minutes or less		Nursing facility discharge day management; more than 30 minutes		Nursing facility discharge day mangement; more than 30 minutes	
4	**Clinical Activity Code**	**Meeting Date: April 21, 2021** **Revision Date (if applicable):** **Tab: 13** **Specialty: AAPM&R, ACP, AGS, AMDA, ANA, APMA**										
5		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
6		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**	**27.0**	**27.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**	**12.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**9.0**	**9.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**	**3.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**18.0**	**18.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**	**9.0**
100	**Supply Code**	**MEDICAL SUPPLIES**										
101		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
102												
103												
104												
105												
106												
107												
108		*Other supply item: to add a new supply item please include the name of the item consistent with the paid invoice here, type NEW in column A and enter the type of unit in column E (oz, ml, unit). Please note that you must include a price estimate consistent with the paid invoice in column D.*										
110	**Equipment Code**	**EQUIPMENT**										
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
112												
113												
114												
115												
116												
117												
118		*Other equipment item: to add a new equipment item please include the name of the item consistent with the paid invoice here, type NEW in column A and please note that you must include a purchase price estimate consistent with the paid invoice in column D.*										

AMA/Specialty Society RVS Update Committee Summary of Recommendations

October 2021

Home and Residence Services – Tab 13

In February 2021, the CPT Editorial Panel deleted twelve of the domiciliary, rest home (e.g., boarding home) and custodial care services to merge these services with the home visit services. The eight revised codes describe home and residence services and align with the principles included in the office or other outpatient E/M office visits by documenting and selecting level of service based on total time or medical decision making.

In April 2021, the specialty societies surveyed the eight home and residence codes but did not obtain the required number of survey responses for the established patients (99347, 99348, 99349 and 99350). More importantly, responses from the predominant provider, such as nurse practitioners, for some of the services were not achieved (99344, 99345, 99349 and 99350). The specialty societies worked with the Research Subcommittee and developed a targeted survey sample methodology, using the Medicare Claims database to identify qualified healthcare professionals, focusing on nurse practitioners, who predominantly perform home visit services and matched them with societies to survey those individuals. The specialty societies also requested to limit the additional surveys to focus on obtaining valid responses from the predominant providers for codes 99344-99450. The Research Subcommittee approved the request to use a targeted survey sample in conjunction with their ongoing use of a random sample methodology. The RUC recommended that the home and residence services be postponed until October 2021 until valid responses were obtained.

New Patient

99341 ***Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.***

The RUC surveyed 93 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 1.00 appropriately accounts for the physician or other qualified healthcare professional(QHP) work required to perform this service. The RUC recommends 6 minutes pre-service time, 15 minutes intra-service time and 6 minutes post-service time. The RUC noted that this service is currently performed by podiatrists 88% of the time based on 2019 Medicare utilization data, however, only 34% of the survey responses were from podiatrists. Therefore, the RUC recommends using the survey 25th percentile intra-service time of 15 minutes, instead of the median of 25 minutes. The 15 minutes of intra-service time is also the median intra-service time specified by the podiatrists who completed the survey. The RUC agreed that this adjustment in time represents a more appropriate intensity for this service. The RUC noted that podiatrists typically perform another CPT code in addition to these codes and any overlap in pre or post-service time would be reduced in the procedure code.

The RUC compared the surveyed code to the top key reference service 99202 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter* (work RVU = 0.93 and 20 minutes total time) and determined that the home or residence visit requires somewhat more physician/QHP work and is more complex than the office visit because the

patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 2 more minutes of total time relative to 99202.

The RUC compared the surveyed code to the second key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 35 minutes total time) and determined that the surveyed code is appropriately lower because it requires less time and a lower level of medical decision-making.

For additional support, the RUC referenced CPT codes 95907 *Nerve conduction studies; 1-2 studies* (work RVU = 1.00 and 15 minutes intra-service time) and 91111 *Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report* (work RVU = 1.00 and 18 minutes intra-service time) as these services require the same physician work and similar time to perform. **The RUC recommends a work RVU of 1.00 for CPT code 99341.**

99342 ***Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***
The RUC surveyed 97 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 1.65 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 10 minutes pre-service time, 32 minutes intra-service time and 10 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99203 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter* (work RVU = 1.60 and 35 minutes total time) and determined that the home or residence visit requires somewhat more physician/QHP work and is more complex than the office visit because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 17 more minutes of total time relative to 99203.

The RUC compared the surveyed code to the second key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.* (work RVU = 2.60 and 60 minutes total time) and determined that the surveyed code is appropriately lower because it requires less time and a lower level of medical decision-making.

For additional support, the RUC referenced CPT codes 76873 *Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)* (work RVU = 1.55 and 30 minutes intra-service time) and 95924 *Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt* (work RVU = 1.73 and 30 minutes intra-service time). **The RUC recommends a work RVU of 1.65 for CPT code 99342.**

99344 ***Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.***
The RUC surveyed 72 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 2.87 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 15 minutes pre-service time, 60 minutes intra-service time and 17 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.* (work RVU = 2.60 and 60 minutes total time) and determined that the home or residence visit requires more physician/QHP work and is more complex than the office visit because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 32 more minutes of total time relative to 99204.

The RUC compared the surveyed code to the second top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined that the surveyed code is appropriately lower because it requires less physician/QHP work and a lower level of medical decision-making.

For additional support, the RUC referenced CPT codes 74712 *Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation* (work RVU = 3.00 and 60 minutes intra-service time), 75563 *Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging* (work RVU = 3.00 and 60 minutes intra-service time), and 95912 *Nerve conduction studies; 11-12 studies* (work RVU = 3.00 and 60 minutes intra-service time) and noted that these services require the same intra-service time and similar work to perform. **The RUC recommends a work RVU of 2.87 for CPT code 99344.**

99345 ***Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making. When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.***
The RUC surveyed 72 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 3.88 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 25 minutes pre-service time, 74 minutes intra-service time and 27 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined

that the home or residence visit requires more physician/QHP work and is more complex than the office visit because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 38 more minutes of total time relative to 99205.

The RUC compared the surveyed code to the second top key reference service 99291 *Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes.* (work RVU = 4.50 and 40 minutes intra-service time) and determined that the surveyed code is appropriately lower because it is a less intense service and requires less work to perform.

For additional support, the RUC referenced CPT codes 95720 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)* (work RVU = 3.86 and 55 minutes intra-service time) and 38240 *Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor* (work RVU = 4.00 and 60 minutes intra-service time) and noted that these services require similar physician work and time to perform and should be valued similarly. **The RUC recommends a work RVU of 3.88 for CPT code 99345.**

Established Patient

99347 ***Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination straightforward medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.***
The RUC surveyed 84 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 0.90 appropriately accounts for the physician or other qualified healthcare provider (QHP) work required to perform this service. The RUC recommends 5 minutes pre-service time, 20 minutes intra-service time and 5 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99212 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.* (work RVU = 0.70 and 16 minutes total time) and determined that the home or residence visit requires more physician/QHP work and is more complex than the analogous established office visit with similar medical decision making, because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 14 more minutes of total time relative to 99212.

The RUC compared the surveyed code to the second top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU = 1.30 and 30 minutes total time) and determined that, even though both services have identical total times, the surveyed code is appropriately valued lower because it requires less physician/QHP work and a lower level of medical decision-making.

For additional support, the RUC referenced CPT codes 78227 *Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed* (work RVU = 0.90 and 15 minutes intra-service time) and 93307 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography* (work RVU = 0.92 and 15 minutes intra-service time) and noted that these services require similar physician work and time to perform and should be valued similarly. **The RUC recommends a work RVU of 0.90 for CPT code 99347.**

99348 ***Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination low medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.***
The RUC surveyed 84 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 1.50 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 7 minutes pre-service time, 29 minutes intra-service time and 10 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99213 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.* (work RVU = 1.30 and 30 minutes total time) and determined that the home or residence visit requires more physician/QHP work and is more complex than the analogous established office visit with similar medical decision making, because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 16 more minutes of total time relative to 99213.

The RUC compared the surveyed code to the second top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU = 1.92 and 47 minutes total time) and determined that the surveyed code is appropriately valued lower because it requires less physician/QHP work and a lower level of medical decision-making.

For additional support, the RUC referenced CPT codes 72195 *Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)* (work RVU = 1.46 and 20 minutes intra-service time) and 78491 *Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)* (work RVU = 1.56 and 15 minutes intra-service time) and noted that these services require similar physician work and should be valued similarly **The RUC recommends a work RVU of 1.50 for CPT code 99348.**

99349 ***Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination moderate medical decision making. When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.***
The RUC surveyed 76 physicians, podiatrists and nurse practitioners and determined that the survey 25th percentile work RVU of 2.44 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 12 minutes pre-service time, 41 minutes intra-service time and 15 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU = 1.92 and 47 minutes total time) and determined that the home or residence visit requires more physician/QHP work and is more complex than the analogous established office visit with similar medical decision making, because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 21 more minutes of total time relative to 99214.

The RUC compared the surveyed code to the second top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.* (work RVU = 2.80 and 70 minutes total time) and determined that the surveyed code is appropriately valued lower because it requires less physician/QHP work and a lower level of medical decision-making.

For additional support, the RUC referenced MPC code 75635 *Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (work RVU = 2.40 and 39 minutes intra-service time) and CPT code 95718 *Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)* (work RVU = 2.50 and 35 minutes intra-service time). **The RUC recommends a work RVU of 2.44 for CPT code 99349.**

99350 ***Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination high medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.***
The RUC surveyed 75 physicians, podiatrists and nurse practitioners and determined that the survey median work RVU of 3.60 appropriately accounts for the physician or other qualified healthcare professional (QHP) work required to perform this service. The RUC recommends 17 minutes pre-service time, 60 minutes intra-service time and 20 minutes post-service time.

The RUC compared the surveyed code to the top key reference service 99215 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.* (work RVU = 2.80 and 70 minutes total time) and determined that the home or residence visit requires more physician/QHP work, time and is more complex than the analogous established office

visit with similar medical decision making, because the patient population is more vulnerable, their conditions are more complex, and the physician/QHP is adjusting to providing all necessary care in an environment away from the office or hospital setting requiring them to bring all necessary supplies. In addition, the surveyed code typically involves 27 more minutes of total time relative to 99214.

The RUC compared the surveyed code to the second top key reference service 99205 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.* (work RVU = 3.50 and 88 minutes total time) and determined that the surveyed code requires the same level of medical decision-making, but requires slightly more time to perform, therefore is appropriately valued slightly higher. This service is the most intense of the home or residence services, these are patients who could reach hospital level care because they are hospital-adverse or because of the characteristics of their care goals, the plan is to keep them in the home environment.

For additional support, the RUC referenced CPT codes 75959 *Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation* (work RVU = 3.50 and 45 minutes intra-service time) and 50329 *Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each* (work RVU = 3.34 and 45 minutes intra-service time). **The RUC recommends a work RVU of 3.60 for CPT code 99350.**

CPT Descriptor Time
The RUC recommends the following times for the CPT descriptors based on the survey medians. The times in the CPT descriptors were rounded from the survey intra-service time to be an increment between this family of services for the ease of those who may report these services based on time.

CPT Code	Descriptor	Time on the Date of Encounter Recommendation to CPT
99341	Home or residence visit new pt, straightforward MDM	**15**
99342	Home or residence visit new pt, low MDM	**30**
99344	Home or residence visit new pt, moderate MDM	**60**
99345	Home or residence visit new pt, high MDM	**75**
99347	Home or residence visit est pt, straightforward MDM	**20**
99348	Home or residence visit est pt, low MDM	**30**
99349	Home or residence visit est pt, moderate MDM	**40**
99350	Home or residence visit est pt, high MDM	**60**

Practice Expense
The Practice Expense Subcommittee reviewed the non-facility direct practice expense inputs and adjusted the supplies for the typical patient by removing SM025 *specula tip, otoscope,* SK062 *patient education booklet* and SJ061 *tongue depressor* for established patient codes 99347, 99348, 99349 and 99350. The Subcommittee also made a revision to 99347 to remove the phone call for CA038 *Coordinate post-procedure services* reflecting the typical specialty (podiatry). **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services** ~~The following codes are used to report evaluation and management services in a facility which provides room, board and other personal assistance services, generally on a long-term basis. These codes include evaluation and management services provided in an assisted living facility, group home, custodial care, and intermediate care facilities.~~ ~~The facility's services do not include a medical component.~~ ~~For definitions of key components and commonly used terms, please see **Evaluation and Management Services Guidelines.**~~ ~~(For care plan oversight services provided to a patient in a domiciliary facility under the care of a home health agency, see 99374, 99375, and for hospice agency, see 99377, 99378. For care plan oversight provided to a patient not under hospice or home health agency care, see 99339, 99340)~~ **New Patient** (99324, 99325, 99326, 99327, 99328 have been deleted. For domiciliary, rest home [eg, boarding home], or custodial care services, new patient, see home and residence services codes 99341, 99342, 99344, 99345)				
~~99324~~	-	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • ~~**A problem focused history;**~~ • ~~**A problem focused examination; and**~~	~~XXX~~	~~N/A~~ (2021 work RVU = 1.01)

		• **Straightforward medical decision making.** Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver.		
99325	-	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: • **An expanded problem focused history;** • **An expanded problem focused examination; and** • **Medical decision making of low complexity.** Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.	XXX	N/A (2021 work RVU = 1.52)
99326	-	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: • **A detailed history;** • **A detailed examination; and** • **Medical decision making of moderate complexity.** Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.	XXX	N/A (2021 work RVU = 2.63)

~~99327~~	-	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~ (2021 work RVU = 3.46)
~~99328~~	-	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~ (2021 work RVU = 4.09)
Established Patient (99334, 99335, 99336, 99337 have been deleted. For domiciliary, rest home [eg, boarding home], or custodial care services, established patient, see home and residence services codes 99347, 99348, 99349, 99350)				
~~99334~~	-	~~Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:~~ • ~~**A problem focused history;**~~	~~XXX~~	~~N/A~~ (2021 work RVU = 1.07)

		• **A problem focused examination;** • **Straightforward medical decision making.** Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.		
99335	-	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: • **An expanded problem focused history;** • **An expanded problem focused examination;** • **Medical decision making of low complexity.** Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.	XXX	N/A (2021 work RVU = 1.72)
99336	-	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: • **A detailed interval history;** • **A detailed examination;** • **Medical decision making of moderate complexity.** Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or	XXX	N/A (2021 work RVU = 2.46)

		~~caregiver.~~		
~~99337~~	-	~~Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:~~ • ~~**A comprehensive interval history;**~~ • ~~**A comprehensive examination;**~~ • ~~**Medical decision making of moderate to high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.~~	~~XXX~~	~~N/A~~ (2021 work RVU = 3.58)
Domiciliary, Rest Home (eg, Assisted Living Facility), or Home Care Plan Oversight Services ~~(For instructions on the use of 99339, 99340, see introductory notes for 99374-99380)~~ ~~(For care plan oversight services for patients under the care of a home health agency, hospice, or nursing facility, see 99374-99380)~~ ~~(Do not report 99339, 99340 for time reported with 98966, 98967, 98968, 99421, 99422, 99423, 99441,99442, 99443)~~ (99339, 99340 have been deleted. For domiciliary, rest home [eg, assisted living facility], or home care plan oversight services, see Care Management Services codes 99491, 99X21, or Principal Care Management codes 99X22, 99X23)				
~~99339~~	-	~~Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy,~~	~~XXX~~	~~N/A~~ (2021 work RVU = 1.25)

		~~within a calendar month; 15-29 minutes~~		
~~99340~~	-	~~30 minutes or more~~ ~~(Do not report 99339, 99340 for patients under the care of a home health agency, enrolled in a hospice program, or for nursing facility residents)~~ ~~(Do not report 99339, 99340 during the same month with 99487-99489)~~	~~XXX~~	~~N/A~~ (2021 work RVU = 1.80)

Home and Residence Services

The following codes are used to report evaluation and management services provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship).

For definitions of ~~key components and~~ commonly used terms, ~~please~~ see **Evaluation and Management Services Guidelines.**

~~(For care plan oversight services provided to a patient in the home under the care of a home health agency, see 99374, 99375, and for hospice agency, see 99377, 99378. For care plan oversight provided to a patient under hospice or home health agency care, see 99339, 99340)~~

These codes are also used when the residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.

For services in an intermediate care facility for individuals with intellectual disabilities and services provided in a psychiatric residential treatment center, see **Nursing Facility Services**.

When selecting code level using time, do not count any travel time.

To report services when a patient is admitted to hospital inpatient, observation status, or to a nursing facility in the course of an encounter in another setting, see **Initial Hospital Inpatient and Observation Care** or **Initial Nursing Facility Care**.

New Patient				
▲99341	J1	**Home or residence visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. ~~these 3 key components:~~ • ~~**A problem focused history;**~~ • ~~**A problem focused examination; and**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver.~~ When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.	XXX	1.00
▲99342	J2	**Home or residence visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. ~~these 3 key components:~~ • ~~**An expanded problem focused history;**~~ • ~~**An expanded problem focused examination; and**~~ • ~~**Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.~~ When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	XXX	1.65

~~99343~~	-	~~**Home visit** for the evaluation and management of a new patient, which requires these 3 key components:~~ • ~~**A detailed history;**~~ • ~~**A detailed examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.~~ (99343 has been deleted. To report, see 99341, 99342, 99344, 99345)	~~XXX~~	~~N/A~~
▲99344	J3	**Home or residence visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.	XXX	2.87

▲99345	J4	**Home or residence visit** for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components:~~ • ~~**A comprehensive history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making of high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded. (For services 90 minutes or longer, see prolonged services code 99417)	XXX	3.88
Established Patient				
▲99347	J5	**Home or residence visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination straightforward medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A problem focused history;**~~ • ~~**A problem focused examination; and**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded.	XXX	0.90

▲99348	J6	**Home or residence visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**An expanded problem focused interval history;**~~ • ~~**An expanded problem focused examination;**~~ • ~~**Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.	XXX	1.50
▲99349	J7	**Home or residence visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A detailed examination;**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.	XXX	2.44

▲99350	J8	**Home <u>or residence</u> visit** for the evaluation and management of an established patient, which requires <u>a medically appropriate history and/or examination and high level of medical decision making.</u> ~~at least 2 of these 3 key components:~~ • ~~**A comprehensive interval history;**~~ • ~~**A comprehensive examination;**~~ • ~~**Medical decision making of moderate to high complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.</u> <u>(For services 75 minutes or longer, see prolonged service code 99417)</u>	XXX	3.60

CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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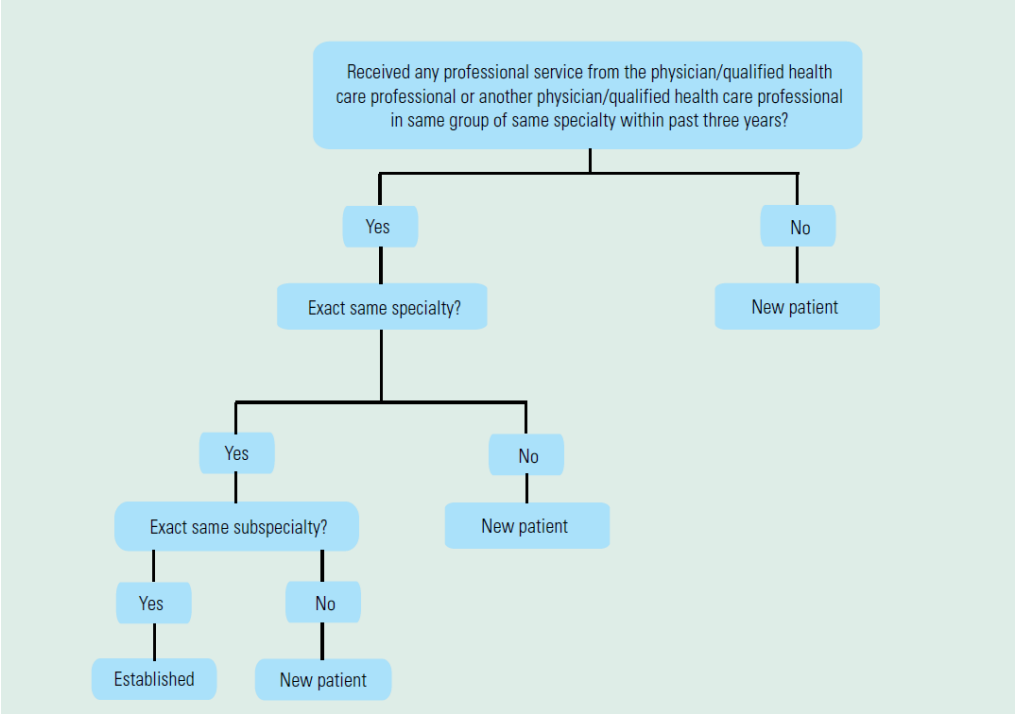
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99341 Tracking Number J1 Original Specialty Recommended RVU: **1.50**
Presented Recommended RVU: **1.00**
Global Period: XXX Current Work RVU: **1.01** RUC Recommended RVU: **1.00**

CPT Descriptor: Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Home or residence visit for a new patient with a self-limited problem.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review available prior medical records and/or data. Place requests for other records and data as necessary. Coordinate with other members of the health care team regarding the home or residence service.

Description of Intra-Service Work: Confirm patient's identity. Obtain vital signs. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan requiring straightforward medical decision making [MDM]. Discuss the treatment plan with patient and/or family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write orders, as necessary, for diagnostic imaging, labs, tests and/or therapeutic intervention(s). [Note: This service is provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship). A residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.]

Description of Post-Service Work: Document the encounter in the medical record. Communicate imaging/labs/test results and additional care plans to other health care professionals and to the patient and/or family/caregiver. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver and respond to treatment failures.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Audrey Chun, MD; Michael Perskin, MD; Korinne, Van Keuren, DNP, APRN; Elisabeth Volpert, DNP, APRN; Brooke Bisbee, DPM					
Specialty Society(ies):	American Geriatrics Society, American Nurses Association, American Podiatric Medical Association , and the American Academy of Home Care Medicine.					
CPT Code:	99341					
Sample Size:	10079	**Resp N:**	93			
Description of Sample:	Random and use of the Medicare Claims data to identify additional survey participants, this method was review and approved by research subcommittee					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**1.00**	4.00	500.00
Survey RVW:	0.80	1.00	**1.50**	1.80	45.00
Pre-Service Evaluation Time:			**6.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	1.00	15.00	**25.00**	40.00	60.00

Immediate Post Service-Time:	**6.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99341	**Recommended Physician Work RVU: 1.00**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**6.00**	**0.00**	**6.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**6.00**	**0.00**	**6.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99202	XXX	0.93	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73721	XXX	1.35	**RUC Time**	670,662

CPT Descriptor 1 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93351	XXX	1.75	**RUC Time**	241,940

CPT Descriptor 2 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 45 **% of respondents:** 48.3 **%**

Number of respondents who choose 2nd Key Reference Code: 30 **% of respondents:** 32.2 **%**

TIME ESTIMATES (Median)

	CPT Code: 99341	Top Key Reference CPT Code: 99202	2nd Key Reference CPT Code: **99203**
Median Pre-Service Time	6.00	2.00	5.00
Median Intra-Service Time	15.00	15.00	25.00
Median Immediate Post-service Time	6.00	3.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**27.00**	**20.00**	**35.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	49%	49%	2%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	9%	51%	40%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	80%	20%
Physical effort required	0%	47%	53%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	69%	31%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	47%	40%	13%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	7%	60%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	7%	77%	17%
Physical effort required	0%	30%	70%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	7%	37%	57%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

For CPT 2023, the home and domiciliary E/M codes will be revised to delete codes 99324-99328, 99334-99337, 99343 and revise codes 99341, 99342, 99344, 99345, 99347-99350 to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance abuse treatment facilities. These changes include combining the domiciliary and rest home codes with the home visit codes so there is now a single code that describes these types of visits. In addition, the descriptors were revised to allow reporting that is based on medical decision making or time alone—similar to the office/outpatient visit codes.

The following societies participated in surveying the revised codes: American Geriatrics Society, American Nurses Association, American Podiatric Medical Association (only 99341, 99342, 99347, 99348), and the American Academy of Home Care Medicine.

Survey Analysis

The surveying societies established an expert panel that reviewed the survey data for all eight home visit codes. The expert panel noted that the key reference services chosen by respondents were typically office visit codes that had been revalued for CY 2021.

The expert panel determined that comparing the survey times to the current times would be inappropriate because the current intra-service times are simply the CPT times - they are not based on survey data. Therefore, the expert panel focused its review on comparing the survey times to other comparator codes.

In addition, the expert panel agreed that home visits are typically performed when patients are ill, cannot be seen in the office for a variety of health and socioeconomic situations and that typically they are more intense than office visits.

Recommendation - 99341

We recommend the survey median work RVU of 1.00 and pre/intra/post times 6/15/6.

Key Reference Code Comparison

Code 99202 involves straightforward MDM similar to survey code 99341, however, the intra-service time required for 99341 is 10 minutes (66%) greater than 99202 and the total time is 17 minutes (85%) greater than 99202, and therefore, code 99341 should be valued similar to 99202.

Code 99203 requires the same intra-service time and almost identical total time compared with 99341. However, 99203 involves low complexity MDM. Therefore, the expert panel believes that 99341 should be valued less than 99203.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	**0.93**	0.047	0.047	20	2	15	3
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.	**1.00**	**0.049**	**0.037**	**27**	**6**	**15**	**6**
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	**1.60**	0.046	0.046	35	5	25	5

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	**1.35**	0.056	0.045	30	5	20	5
99341	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.	**1.00**	**0.049**	**0.037**	**27**	**6**	**15**	**6**

93351	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional	**1.75**	0.065	0.044	40	10	20	10

Other Code Comparisons

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
95907	Nerve conduction studies; 1-2 studies	**1.00**	0.037	0.029	35	10	15	10
91111	Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy), esophagus with interpretation and report	**1.00**	0.031	0.026	38	5	18	15

The expert panel agrees that the survey median work RVU of 1.00 places 99341 in proper rank order to the key reference, MPC and other reference codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99324, 99341

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty podiatry How often? Commonly

Specialty nurse practitioner How often? Commonly

Specialty geriatric medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 65,027
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare data for codes 99324 and 99341 - see specialty distribution for each code on the last page

Specialty Podiatry Frequency 57582 Percentage 88.55 %

Specialty Nurse Practitioner Frequency 3091 Percentage 4.75 %

Specialty Physicians Assistant Frequency 1241 Percentage 1.90 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99341

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99324 Claims = 51,495

PODIATRY	88.8%
NURSE PRACTITIONER	4.4%
PHYSICIANS ASSISTANT	2.2%
FAMILY MEDICINE	1.1%
INTERNAL MEDICINE	1.0%
DERMATOLOGY	0.8%

PSYCHIATRY	0.7%
OTOLARYNGOLOGY	0.4%
GENERAL PRACTICE	0.2%
GENERAL SURGERY	0.1%
GERIATRIC MEDICINE	0.1%
PULMONARY DISEASE	0.1%

99341 Claims – 13,532

PODIATRY	87.6%
NURSE PRACTITIONER	6.1%
PAIN MANAGEMENT	3.0%
FAMILY MEDICINE	0.9%
PHYSICIANS ASSISTANT	0.8%
INTERNAL MEDICINE	0.5%
GENERAL PRACTICE	0.3%
GENERAL SURGERY	0.2%
PSYCHIATRY	0.1%
HOSPICE AND PALLIATIVE CARE	0.1%
EMERGENCY MEDICINE	0.1%
GERIATRIC MEDICINE	0.1%
OTOLARYNGOLOGY	0.1%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99342 Tracking Number J2 Original Specialty Recommended RVU: **2.00**
Presented Recommended RVU: **1.65**
Global Period: XXX Current Work RVU: **1.52** RUC Recommended RVU: **1.65**

CPT Descriptor: Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Home or residence visit for a new patient with an acute uncomplicated illness or injury.

Percentage of Survey Respondents who found Vignette to be Typical: 85%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review available prior medical records and/or data. Place requests for other records and data as necessary. Coordinate with other members of the health care team regarding the home or residence service.

Description of Intra-Service Work: Confirm patient's identity. Obtain vital signs. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan requiring low complexity medical decision making [MDM]. Discuss the treatment plan with patient and/or family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write orders, as necessary, for diagnostic imaging, labs, tests and/or therapeutic intervention(s). [Note: This service is provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship). A residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.]

Description of Post-Service Work: Document the encounter in the medical record. Communicate imaging/labs/test results and additional care plans to other health care professionals and to the patient and/or family/caregiver. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver and respond to treatment failures.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Audrey Chun, MD; Michael Perskin, MD; Korinne, Van Keuren, DNP, APRN; Elisabeth Volpert, DNP, APRN; Brooke Bisbee, DPM					
Specialty Society(ies):	American Geriatrics Society, American Nurses Association, American Podiatric Medical Association , and the American Academy of Home Care Medicine.					
CPT Code:	99342					
Sample Size:	10079	**Resp N:**	97			
Description of Sample:	Random and use of the Medicare Claims data to identify additional survey participants, this method was review and approved by research subcommittee					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**10.00**	10.00	1000.00	
Survey RVW:	0.90	1.65	**2.00**	2.60	60.00	
Pre-Service Evaluation Time:			**10.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	1.00	25.00	**32.00**	50.00	90.00	
Immediate Post Service-Time:	**10.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99342	**Recommended Physician Work RVU: 1.65**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**10.00**	**0.00**	**10.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**32.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99203	XXX	1.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99460	XXX	1.92	**RUC Time**	12

CPT Descriptor 1 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
75635	XXX	2.40	**RUC Time**	114,472

CPT Descriptor 2 Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 52 **% of respondents:** 53.6 **%**

Number of respondents who choose 2nd Key Reference Code: 25 **% of respondents:** 25.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 99342	**Top Key Reference CPT Code:** 99203	**2nd Key Reference CPT Code:** **99204**
Median Pre-Service Time	10.00	5.00	10.00
Median Intra-Service Time	32.00	25.00	40.00
Median Immediate Post-service Time	10.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**52.00**	**35.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	48%	44%	8%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	10%	46%	44%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	71%	29%
Physical effort required	0%	48%	52%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	56%	38%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	36%	44%	20%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	56%	44%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	64%	28%
Physical effort required	0%	28%	72%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	32%	68%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

For CPT 2023, the home and domiciliary E/M codes will be revised to delete codes 99324-99328, 99334-99337, 99343 and revise codes 99341, 99342, 99344, 99345, 99347-99350 to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance abuse treatment facilities. These changes include combining the domiciliary and rest home codes with the home visit codes so there is now a single code that describes

these types of visits. In addition, the descriptors were revised to allow reporting that is based on medical decision making or time alone—similar to the office/outpatient visit codes.

The following societies participated in surveying the revised codes: American Geriatrics Society, American Nurses Association, American Podiatric Medical Association (only 99341, 99342, 99347, 99348), and the American Academy of Home Care Medicine

Survey Analysis

The surveying societies established an expert panel that reviewed the survey data for all eight home visit codes. The expert panel noted that the key reference services chosen by respondents were typically office visit codes that had been revalued for CY 2021.

The expert panel determined that comparing the survey times to the current times would be inappropriate because the current intra-service times are simply the CPT times - they are not based on survey data. Therefore, the expert panel focused its review on comparing the survey times to other comparator codes.

In addition, the expert panel agreed that home visits are typically performed when patients are ill, cannot be seen in the office for a variety of health and socioeconomic situation and that typically they are more intense than office visits.

Recommendation - 99342

We recommend the survey median work RVU of 1.65 and pre/intra/post times 10/32/10.

Key Reference Code Comparison

Code 99203 and survey code 99342 both involve low complexity MDM, however, the intra-service time required for 99342 is 7 minutes (28%) greater than 99203 and the total time is 17 minutes (49%) greater than 99203, and therefore, code 99342 should be valued higher than 99203.

Code 99204 requires moderate complexity MDM compared with 99342 which requires low complexity MDM. Both intra-service time and total time for 99204 are greater than 99342, and therefore 99342 should be valued less than 99204.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.	**1.60**	0.046	0.046	35	5	25	5
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.	**1.65**	**0.038**	**0.032**	**52**	**10**	**32**	**10**
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	**2.60**	0.043	0.043	60	10	40	10

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant	**1.92**	0.049	0.038	50	10	30	10
99342	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.	**1.65**	**0.038**	**0.032**	**52**	**10**	**32**	**10**
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	**2.40**	0.051	0.042	57	10	39	8

Other Code Comparisons

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
76873	Ultrasound, transrectal; prostate volume study for brachytherapy treatment planning (separate procedure)	**1.55**	0.029	0.026	60	20	30	10
95924	Testing of autonomic nervous system function; combined parasympathetic and sympathetic adrenergic function testing with at least 5 minutes of passive tilt	**1.73**	0.035	0.029	60	15	30	15

The expert panel agrees that the survey median work RVU of 1.65 places 99342 in proper rank order to the key reference, MPC and other reference codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99325, 99342

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty podiatry How often? Commonly

Specialty nurse practitioner How often? Commonly

Specialty geriatric medicine How often? Commonly

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. National frequency data not available

Specialty Frequency Percentage %

Specialty	Frequency	Percentage	%
Specialty	Frequency	Percentage	%

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 93,646 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare data for codes 99325 and 99342 - see specialty distribution for each code on the last page

Specialty Internal Medicine	Frequency 3904	Percentage 4.16 %
Specialty Nurse Practitioner	Frequency 12391	Percentage 13.23 %
Specialty Physicians Assistant	Frequency 4111	Percentage 4.38 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99342

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99325 Claims = 53,120

PODIATRY	63.7%
NURSE PRACTITIONER	14.4%
INTERNAL MEDICINE	5.9%
FAMILY MEDICINE	4.9%
PHYSICIANS ASSISTANT	4.0%
PSYCHIATRY	1.9%
GENERAL PRACTICE	1.3%
DERMATOLOGY	1.2%
GERIATRIC MEDICINE	0.8%
OPTOMETRY	0.2%
HOSPITALIST	0.2%
EMERGENCY MEDICINE	0.1%

GERIATRIC PSYCHIATRY	0.1%
GENERAL SURGERY	0.1%
PHYSICAL MEDICINE AND REHABILITATION	0.1%
CARDIOLOGY	0.1%
PULMONARY DISEASE	0.1%

99342 Claims = 40,526

PODIATRY	77.1%
NURSE PRACTITIONER	11.7%
PHYSICIANS ASSISTANT	4.9%
FAMILY MEDICINE	1.9%
INTERNAL MEDICINE	1.9%
GENERAL PRACTICE	0.5%
PLASTIC AND RECONSTRUCTIVE SURGERY	0.5%
PAIN MANAGEMENT	0.3%
GENERAL SURGERY	0.2%
GERIATRIC MEDICINE	0.2%
EMERGENCY MEDICINE	0.1%
PSYCHIATRY	0.1%
DIAGNOSTIC RADIOLOGY	0.1%
HOSPICE AND PALLIATIVE CARE	0.1%
OPTOMETRY	0.1%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99344 Tracking Number J3 Original Specialty Recommended RVU: **3.50**
Presented Recommended RVU: **3.00**
Global Period: XXX Current Work RVU: **3.38** RUC Recommended RVU: **2.87**

CPT Descriptor: Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Home or residence visit for a new patient with a progressing illness or acute injury that requires diagnostic evaluation, medical management, or potential surgical treatment..

Percentage of Survey Respondents who found Vignette to be Typical: 81%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review available prior medical records and/or data. Place requests for other records and data as necessary. Coordinate with other members of the health care team regarding the home or residence service.

Description of Intra-Service Work: Confirm patient's identity. Obtain vital signs. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan requiring moderate medical decision making [MDM]. Discuss the treatment plan with patient and/or family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write orders, as necessary, for diagnostic imaging, labs, tests and/or therapeutic intervention(s). [Note: This service is provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship). A residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.]

Description of Post-Service Work: Document the encounter in the medical record. Communicate imaging/labs/test results and additional care plans to other health care professionals and to the patient and/or family/caregiver. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver and respond to treatment failures.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Audrey Chun, MD; Michael Perskin, MD; Korinne, Van Keuren, DNP, APRN; Elisabeth Volpert, DNP, APRN					
Specialty Society(ies):	American Geriatrics Society, American Nurses Association, and the American Academy of Home Care Medicine.					
CPT Code:	99344					
Sample Size:	7719	**Resp N:**	72			
Description of Sample:	Random and use of the Medicare Claims data to identify additional survey participants, this method was review and approved by research subcommittee.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	1.00	5.00	**10.00**	35.00	209.00
Survey RVW:	0.50	2.87	**3.50**	3.79	65.00
Pre-Service Evaluation Time:			**15.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	6.00	40.00	**60.00**	75.00	100.00

Immediate Post Service-Time:	**17.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99344	**Recommended Physician Work RVU: 2.87**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**15.00**	**0.00**	**15.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**17.00**	**0.00**	**17.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	0.00	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.80	**RUC Time**	10,388,878

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
31628	XXX	3.55	**RUC Time**	32,291

CPT Descriptor 2 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 35 **% of respondents:** 48.6 **%**

Number of respondents who choose 2nd Key Reference Code: 24 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 99344	Top Key Reference CPT Code: 99204	2nd Key Reference CPT Code: **99205**
Median Pre-Service Time	15.00	10.00	14.00
Median Intra-Service Time	60.00	40.00	59.00
Median Immediate Post-service Time	17.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**92.00**	**60.00**	**88.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	11%	63%	26%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	29%	71%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	3%	43%	54%
Physical effort required	0%	23%	77%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	20%	80%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	4%	4%	4%	67%	21%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	29%	62%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	33%	72%
Physical effort required	0%	25%	75%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	4%	87%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

For CPT 2023, the home and domiciliary E/M codes will be revised to delete codes 99324-99328, 99334-99337, 99343 and revise codes 99341, 99342, 99344, 99345, 99347-99350 to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance abuse treatment facilities. These changes include combining the domiciliary and rest home codes with the home visit codes so there is now a single code that describes these types of visits. In addition, the descriptors were revised to allow reporting that is based on medical decision making or time alone—similar to the office/outpatient visit codes.

The following societies participated in surveying the revised codes: American Geriatrics Society, American Nurses Association, American Podiatric Medical Association (only 99341, 99342, 99347, 99348), and the American Academy of Home Care Medicine.

Survey Analysis

The surveying societies established an expert panel that reviewed the survey data for all eight home visit codes. The expert panel noted that the key reference services chosen by respondents were typically office visit codes that had been revalued for CY 2021.

The expert panel determined that comparing the survey times to the current times would be inappropriate because the current intra-service times are simply the CPT times - they are not based on survey data. Therefore, the expert panel focused its review on comparing the survey times to other comparator codes.

In addition, the expert panel agreed that home visits are typically performed when patients are ill, cannot be seen in the office for a variety of health and socioeconomic situations and that typically they are more intense than office visits.

Recommendation - 99344

We recommend the 25th survey value for a work RVU of 2.87 and pre/intra/post times 15/60/17.

There were 72 respondents of whom 81% found the vignette to be typical. The survey times were 15/60/17/92.

Key Reference Code Comparison

Code 99204 involves moderate MDM similar to survey code 99344, however, the intra-service time required for 99344 is 20 minutes greater than 99204 and the total time is 32 minutes greater than 99204, and therefore, code 99344 should be valued higher than 99204.

Code 99205 requires the similar intra-service time and 4 less minutes of total time compared with 99344. However, 99205 involves high complexity MDM. Therefore, the expert panel believes that 99344 should be valued slightly less than 99205.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.	**2.60**	0.054	0.043	60	10	40	15
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making.	**2.87**	**0.036**	**0.031**	**92**	**15**	**60**	**17**
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	**3.50**	0.048	0.040	88	14	59	15

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	**2.80**	0.47	0.37	75	10	45	20
99344	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate medical decision making.	**2.87**	**0.036**	**0.031**	**92**	**15**	**60**	**17**
31628	Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with transbronchial lung biopsy(s), single lobe	**3.55**	0.069	0.046	78	18	40	20

Other Code Comparisons

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
74712	Magnetic resonance (eg, proton) imaging, fetal, including placental and maternal pelvic imaging when performed; single or first gestation	**3.00**	**0.039**	**0.033**	**90**	**15**	**60**	**15**
75563	Cardiac magnetic resonance imaging for morphology and function without contrast material(s), followed by contrast material(s) and further sequences; with stress imaging	**3.00**	0.042	0.037	82	12	60	10
95912	Nerve conduction studies; 11-12 studies	**3.00**	0.039	0.033	90	15	60	15

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99326, 99327, 99343, 99344

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty NURSE PRACTITIONER How often? Commonly

Specialty FAMILY MEDICINE How often? Sometimes

Specialty INTERNAL MEDICINE How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
257,046 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare data for codes 99326, 99343, 99344 - see specialty distribution for each code on the last page

Specialty podiatry Frequency 50124 Percentage 19.50 %

Specialty Internal Medicine Frequency 28918 Percentage 11.25 %

Specialty Nurse Practitioner Frequency 106675 Percentage 41.50 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99344

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99326 Claims = 57,317

NURSE PRACTITIONER	37.4%
INTERNAL MEDICINE	15.2%
PODIATRY	15.0%

FAMILY MEDICINE	10.9%
PHYSICIANS ASSISTANT	6.7%
OPTOMETRY	4.1%
PSYCHIATRY	3.2%
GERIATRIC MEDICINE	1.7%
GENERAL PRACTICE	1.2%
GERIATRIC PSYCHIATRY	0.7%
CARDIOLOGY	0.6%
OTOLARYNGOLOGY	0.4%

99343 Claims – 56,201

PODIATRY	46.3%
NURSE PRACTITIONER	30.3%
FAMILY MEDICINE	7.1%
INTERNAL MEDICINE	6.2%
PHYSICIANS ASSISTANT	4.9%
GENERAL PRACTICE	1.5%
OPTOMETRY	0.5%
GERIATRIC MEDICINE	0.4%
HOSPICE AND PALLIATIVE CARE	0.3%
EMERGENCY MEDICINE	0.3%
GENERAL SURGERY	0.2%
PLASTIC AND RECONSTRUCTIVE SURGERY	0.2%
NEUROLOGY	0.2%

99344 Claims – 76,381

NURSE PRACTITIONER	52.4%
FAMILY MEDICINE	13.9%
INTERNAL MEDICINE	12.3%
PHYSICIANS ASSISTANT	5.4%
PODIATRY	2.8%
GENERAL PRACTICE	2.5%
OPTOMETRY	2.5%
EMERGENCY MEDICINE	1.5%
GERIATRIC MEDICINE	1.0%
CARDIOLOGY	0.7%
HOSPICE AND PALLIATIVE CARE	0.6%
CERTIFIED CLINICAL NURSE SPECIALIST	0.5%
GENERAL SURGERY	0.5%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99345 Tracking Number J4 Original Specialty Recommended RVU: **4.00**
Presented Recommended RVU: **3.88**
Global Period: XXX Current Work RVU: **4.09** RUC Recommended RVU: **3.88**

CPT Descriptor: Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Home or residence visit for a new patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review available prior medical records and/or data. Place requests for other records and data as necessary. Coordinate with other members of the health care team regarding the home or residence service.

Description of Intra-Service Work: Confirm patient's identity. Obtain vital signs. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan requiring high medical decision making [MDM]. Discuss the treatment plan with patient and/or family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write orders, as necessary, for diagnostic imaging, labs, tests and/or therapeutic intervention(s). [Note: This service is provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship). A residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.]

Description of Post-Service Work: Document the encounter in the medical record. Communicate imaging/labs/test results and additional care plans to other health care professionals and to the patient and/or family/caregiver. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver and respond to treatment failures.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Audrey Chun, MD; Michael Perskin, MD; Korinne, Van Keuren, DNP, APRN; Elisabeth Volpert, DNP, APRN					
Specialty Society(ies):	American Geriatrics Society, American Nurses Association, and the American Academy of Home Care Medicine.					
CPT Code:	99345					
Sample Size:	7719	**Resp N:**	72			
Description of Sample:	Random and use of the Medicare Claims data to identify additional survey participants, this method was review and approved by research subcommittee.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	20.00	400.00
Survey RVW:	0.20	3.88	**4.00**	4.50	75.00
Pre-Service Evaluation Time:			**25.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	8.00	55.00	**74.00**	90.00	120.00

Immediate Post Service-Time:	**27.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99345	**Recommended Physician Work RVU: 3.88**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**25.00**	**0.00**	**25.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**74.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**27.00**	**0.00**	**27.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99291	XXX	4.50	**RUC Time**

CPT Descriptor Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90962	XXX	3.57	**RUC Time**	213,048

CPT Descriptor 1 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99291	XXX	4.50	**RUC Time**	5,905,780

CPT Descriptor 2 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 35 **% of respondents:** 48.6 **%**

Number of respondents who choose 2nd Key Reference Code: 18 **% of respondents:** 25.0 **%**

TIME ESTIMATES (Median)

	CPT Code: 99345	**Top Key Reference CPT Code:** 99205	**2nd Key Reference CPT Code:** **99291**
Median Pre-Service Time	25.00	14.00	15.00
Median Intra-Service Time	74.00	59.00	40.00
Median Immediate Post-service Time	27.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**126.00**	**88.00**	**70.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES

(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	12%	24%	65%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	21%	79%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	35%	65%

Physical effort required	0%	15%	85%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	17%	83%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	6%	28%	11%	45%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	56%	33%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	11%	50%	39%
Physical effort required	0%	33%	67%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	6%	50%	44%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

For CPT 2023, the home and domiciliary E/M codes will be revised to delete codes 99324-99328, 99334-99337, 99343 and revise codes 99341, 99342, 99344, 99345, 99347-99350 to include services provided in assisted living facilities,

group homes, custodial care facilities, and residential substance abuse treatment facilities. These changes include combining the domiciliary and rest home codes with the home visit codes so there is now a single code that describes these types of visits. In addition, the descriptors were revised to allow reporting that is based on medical decision making or time alone—similar to the office/outpatient visit codes.

The following societies participated in surveying the revised codes: American Geriatrics Society, American Nurses Association, American Podiatric Medical Association (only 99341, 99342, 99347, 99348), and the American Academy of Home Care Medicine.

Survey Analysis

The surveying societies established an expert panel that reviewed the survey data for all eight home visit codes. The expert panel noted that the key reference services chosen by respondents were typically office visit codes that had been revalued for CY 2021.

The expert panel determined that comparing the survey times to the current times would be inappropriate because the current intra-service times are simply the CPT times - they are not based on survey data. Therefore, the expert panel focused its review on comparing the survey times to other comparator codes.

In addition, the expert panel agreed that home visits are typically performed when patients are ill, cannot be seen in the office for a variety of health and socioeconomic situations and that typically they are more intense than office visits.

Recommendation - 99345

We recommend the survey 25th percentile work RVU of 3.88 and pre/intra/post times 15/60/17.

There were 72 respondents of whom 81% found the vignette to be typical. The survey times were 15/60/17/92 and the median and 25th percentile work RVUs were 3.50 and 2.87 respectively.

Key Reference Code Comparison

Code 99205 involves high MDM similar to survey code 99345, however, the intra-service time required for 99345 is 15 minutes greater than 99205 and the total time is 38 minutes greater than 99205, and therefore, code 99345 should be valued higher than 99205.

Code 99291 requires less intra-service and total time compared with 99345. However, 99291 involves high complexity MDM. Therefore, the expert panel believes that 99345 should be valued less than 99291.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	**3.50**	0.040	0.040	88	14	59	15
99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making.	**3.88**	**0.037**	**0.031**	**126**	**25**	**74**	**27**
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes	**4.50**	**0.096**	**0.064**	**70**	**15**	**40**	**15**

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional **per month**	**3.57**	**0.051**	**0.051**	**70**	**0**	**70**	**0**
99345	Home or residence visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high medical decision making.	**3.88**	**0.037**	**0.031**	**126**	**25**	**74**	**27**
99291	Critical care, evaluation and management of the critically	**4.50**	**0.096**	**0.064**	**70**	**15**	**40**	**15**

	ill or critically injured patient; **first 30-74 minutes**							

Other Code Comparisons

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
95720	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; with video (VEEG)	**3.86**	0.051	0.029	75	10	55	10
38240	Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	**4.00**	0.044	0.033	120	30	60	30

The expert panel agrees that the survey 25th percentile work RVU of 3.88 places 99345 in proper rank order to the key reference, MPC and other reference codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99328, 99345

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty NURSE PRACTITIONER How often? Commonly

Specialty FAMILY MEDICINE How often? Sometimes

Specialty INTERNAL MEDICINE How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 113,596 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare data for codes 99328, 99345 - see specialty distribution for each code on the last page

Specialty Internal medicine Frequency 17040 Percentage 15.00 %

Specialty Family medicine Frequency 13291 Percentage 11.70 %

Specialty Nurse Practitioner Frequency 53243 Percentage 46.87 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99345

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99328 Claims – 42,033

NURSE PRACTITIONER	47.5%
INTERNAL MEDICINE	16.7%
FAMILY MEDICINE	12.0%
PHYSICIANS ASSISTANT	8.1%
PSYCHIATRY	2.9%
GERIATRIC MEDICINE	2.4%
OPTOMETRY	2.1%
GENERAL PRACTICE	1.4%
PODIATRY	1.2%
OPHTHALMOLOGY	0.7%

CERTIFIED CLINICAL NURSE SPECIALIST	0.7%
CARDIOLOGY	0.6%
GERIATRIC PSYCHIATRY	0.5%

99345 Claims – 71,563

NURSE PRACTITIONER	55.4%
INTERNAL MEDICINE	13.8%
FAMILY MEDICINE	12.3%
PHYSICIANS ASSISTANT	6.6%
GENERAL PRACTICE	3.8%
GERIATRIC MEDICINE	1.5%
HOSPICE AND PALLIATIVE CARE	0.8%
GENERAL SURGERY	0.6%
PREVENTIVE MEDICINE	0.6%
CARDIOLOGY	0.6%
NEPHROLOGY	0.5%
EMERGENCY MEDICINE	0.4%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99347 Tracking Number J5 Original Specialty Recommended RVU: **1.30**
Presented Recommended RVU: **0.90**
Global Period: XXX Current Work RVU: **1.00** RUC Recommended RVU: **0.90**

CPT Descriptor: Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination straightforward medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Home or residence visit for an established patient with an uncomplicated illness or injury.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review interval correspondence, referral notes, and/or medical records generated since the last home or residence service. Coordinate with other members of the health care team regarding the home or residence service.

Description of Intra-Service Work: Confirm patient's identity. Review prior clinical notes. Obtain vital signs. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan requiring straightforward medical decision making [MDM]. Discuss the treatment plan with patient and/or family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write orders, as necessary, for diagnostic imaging, labs, tests and/or therapeutic intervention(s). [Note: This service is provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship). A residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.]

Description of Post-Service Work: Document the encounter in the medical record. Communicate imaging/labs/test results and additional care plans to other health care professionals and to the patient and/or family/caregiver .Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver and respond to treatment failures.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Audrey Chun, MD; Michael Perskin, MD; Korinne, Van Keuren, DNP, APRN; Elisabeth Volpert, DNP, APRN; Brooke Bisbee, DPM					
Specialty Society(ies):	American Geriatrics Society, American Nurses Association, American Podiatric Medical Association , and the American Academy of Home Care Medicine.					
CPT Code:	99347					
Sample Size:	10079	**Resp N:**	84			
Description of Sample:	Random and use of the Medicare Claims data to identify additional survey participants, this method was review and approved by research subcommittee					
	Low	**25th pctl**	**Median***	**75th pctl**	**High**	
Service Performance Rate	0.00	0.00	**3.00**	10.00	700.00	
Survey RVW:	0.18	0.90	**1.30**	1.91	30.00	
Pre-Service Evaluation Time:			**5.00**			
Pre-Service Positioning Time:			**0.00**			
Pre-Service Scrub, Dress, Wait Time:			**0.00**			
Intra-Service Time:	1.00	12.00	**20.00**	30.00	60.00	
Immediate Post Service-Time:	**5.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99347	**Recommended Physician Work RVU: 0.90**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**5.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**20.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**5.00**	**0.00**	**5.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99212	XXX	0.70	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	2,490,658

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
73721	XXX	1.35	**RUC Time**	670,662

CPT Descriptor 2 Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 36 **% of respondents:** 42.8 **%**

Number of respondents who choose 2nd Key Reference Code: 28 **% of respondents:** 33.3 **%**

TIME ESTIMATES (Median)

	CPT Code: 99347	**Top Key Reference CPT Code:** 99212	**2nd Key Reference CPT Code:** **99213**
Median Pre-Service Time	5.00	2.00	5.00
Median Intra-Service Time	20.00	11.00	20.00
Median Immediate Post-service Time	5.00	3.00	5.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**16.00**	**30.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	50%	50%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	3%	53%	44%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	72%	28%
Physical effort required	0%	36%	64%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	67%	33%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	50%	43%	7%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	46%	43%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	18%	50%	32%
Physical effort required	0%	39%	61%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	25%	71%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

For CPT 2023, the home and domiciliary E/M codes will be revised to delete codes 99324-99328, 99334-99337, 99343 and revise codes 99341, 99342, 99344, 99345, 99347-99350 to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance abuse treatment facilities. These changes include combining the domiciliary and rest home codes with the home visit codes so there is now a single code that describes

these types of visits. In addition, the descriptors were revised to allow reporting that is based on medical decision making or time alone—similar to the office/outpatient visit codes.

The following societies participated in surveying the revised codes: American Geriatrics Society, American Nurses Association, American Podiatric Medical Association (only 99341, 99342, 99347, 99348), and the American Academy of Home Care Medicine

Survey Analysis

The surveying societies established an expert panel that reviewed the survey data for all eight home visit codes. The expert panel noted that the key reference services chosen by respondents were typically office visit codes that had been revalued for CY 2021.

The expert panel determined that comparing the survey times to the current times would be inappropriate because the current intra-service times are simply the CPT times - they are not based on survey data. Therefore, the expert panel focused its review on comparing the survey times to other comparator codes.

In addition, the expert panel agreed that home visits are typically performed when patients are ill, cannot be seen in the office for a variety of health and socioeconomic situations and that typically they are more intense than office visits.

Recommendation - 99347

We recommend the survey 25th percentile work RVU of 0.90 and pre/intra/post times 5/20/5.

Key Reference Code Comparison

Code 99212 and survey code 99347 both involve straightforward MDM, however, the intra-service time required for 99347 is 9 minutes (45%) greater than 99212 and the total time is 14 minutes (88%) greater than 99212, and therefore, code 99347 should be valued higher than 99212.

Code 99213 requires low complexity MDM compared with 99347 which requires straightforward MDM. Both codes require the same pre/intra/post-time. This service is typically billed with a procedure.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.	**0.70**	0.053	0.044	16	2	11	3
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination straightforward medical decision making.	**0.90**	**0.034**	**0.030**	**30**	**5**	**20**	**5**
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	**1.30**	0.054	0.043	30	5	20	5

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.	**0.93**	0.055	0.047	20	2	15	3
99347	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination straightforward medical decision making.	**0.90**	**0.034**	**0.030**	**30**	**5**	**20**	**5**
73721	Magnetic resonance (eg, proton) imaging, any joint of lower extremity; without contrast material	**1.35**	0.056	0.045	30	5	20	5

Other Code Comparisons

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
78227	Hepatobiliary system imaging, including gallbladder when present; with pharmacologic intervention, including quantitative measurement(s) when performed	**0.90**	0.044	0.035	25	6	15	5
93307	Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, without spectral or color Doppler echocardiography	**0.92**	0.046	0.037	25	5	15	5

The expert panel agrees that the survey 25th percentile work RVU of 0.90 places 99347 in proper rank order to the key reference, MPC and other reference codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99334, 99347

How often do physicians <u>in your specialty</u> perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty podiatry How often? Commonly

Specialty nurse practitioner How often? Commonly

Specialty geriatric medicing How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and <u>percentage</u> for each specialty. Please explain the rationale for this estimate. National frequency data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 678,108 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare data for codes 99334 and 99347 - see specialty distribution for each code on the last page

Specialty Podiatry Frequency 261411 Percentage 38.55 %

Specialty Internal Medicine Frequency 60962 Percentage 8.99 %

Specialty Nurse Practioner Frequency 171494 Percentage 25.29 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99342

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99334 Claims = 500,533

PODIATRY	30.7%
NURSE PRACTITIONER	28.8%
INTERNAL MEDICINE	10.0%
FAMILY MEDICINE	9.4%
PSYCHIATRY	8.9%
PHYSICIANS ASSISTANT	4.3%
GENERAL PRACTICE	2.1%
GERIATRIC PSYCHIATRY	2.0%
GERIATRIC MEDICINE	1.2%
CERTIFIED CLINICAL NURSE SPECIALIST	0.6%
EMERGENCY MEDICINE	0.3%
DERMATOLOGY	0.3%
PULMONARY DISEASE	0.2%
GASTROENTEROLOGY	0.2%
CARDIOLOGY	0.1%

GENERAL SURGERY	0.1%
PHYSICAL MEDICINE AND REHABILITATION	0.1%
NEPHROLOGY	0.1%
OPTOMETRY	0.1%
HOSPITALIST	0.1%
OTOLARYNGOLOGY	0.1%
RHEUMATOLOGY	0.1%

99347 Claims = 177,575

PODIATRY	72.0%
NURSE PRACTITIONER	10.4%
FAMILY MEDICINE	5.4%
INTERNAL MEDICINE	4.7%
PSYCHIATRY	2.4%
PHYSICIANS ASSISTANT	1.6%
GENERAL PRACTICE	1.5%
GERIATRIC MEDICINE	0.5%
PUBLIC HEALTH OR WELFARE AGENCY	0.3%
CERTIFIED CLINICAL NURSE SPECIALIST	0.3%
GENERAL SURGERY	0.1%
EMERGENCY MEDICINE	0.1%
HOSPITALIST	0.1%
OPTOMETRY	0.1%
PREVENTIVE MEDICINE	0.1%
CARDIOLOGY	0.1%
HOSPICE AND PALLIATIVE CARE	0.1%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99348 Tracking Number J6 Original Specialty Recommended RVU: **1.92**
Presented Recommended RVU: **1.50**
Global Period: XXX Current Work RVU: **1.56** RUC Recommended RVU: **1.50**

CPT Descriptor: Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Home or residence visit for an established patient with a stable chronic illness or acute uncomplicated injury.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review interval correspondence, referral notes, and/or medical records generated since the last home or residence service. Coordinate with other members of the health care team regarding the home or residence service.

Description of Intra-Service Work: Confirm patient's identity. Review prior clinical notes. Obtain vital signs. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan requiring low complexity medical decision making [MDM]. Discuss the treatment plan with patient and/or family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write orders, as necessary, for diagnostic imaging, labs, tests and/or therapeutic intervention(s). [Note: This service is provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship). A residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.]

Description of Post-Service Work: Document the encounter in the medical record. Communicate imaging/labs/test results and additional care plans to other health care professionals and to the patient and/or family/caregiver .Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver and respond to treatment failures.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021		
Presenter(s):	Audrey Chun, MD; Michael Perskin, MD; Korinne, Van Keuren, DNP, APRN; Elisabeth Volpert, DNP, APRN; Brooke Bisbee, DPM		
Specialty Society(ies):	American Geriatrics Society, American Nurses Association, American Podiatric Medical Association , and the American Academy of Home Care Medicine.		
CPT Code:	99348		
Sample Size:	10079	**Resp N:**	84
Description of Sample:	Random and use of the Medicare Claims data to identify additional survey participants, this method was review and approved by research subcommittee		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**5.00**	30.00	1000.00
Survey RVW:	0.20	1.50	**1.92**	2.13	35.00
Pre-Service Evaluation Time:			**7.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	4.00	20.00	**29.00**	35.00	60.00

Immediate Post Service-Time:	**10.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99348	**Recommended Physician Work RVU: 1.50**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**7.00**	**0.00**	**7.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**29.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**10.00**	**0.00**	**10.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99213	XXX	1.30	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74170	XXX	1.40	**RUC Time**	107,476

CPT Descriptor 1 Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74178	XXX	2.01	**RUC Time**	534,971

CPT Descriptor 2 Computed tomography, abdomen and pelvis; without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:

Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 44 **% of respondents:** 52.3 **%**

Number of respondents who choose 2nd Key Reference Code: 24 **% of respondents:** 28.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 99348	Top Key Reference CPT Code: 99213	2nd Key Reference CPT Code: **99214**
Median Pre-Service Time	7.00	5.00	7.00
Median Intra-Service Time	29.00	20.00	30.00
Median Immediate Post-service Time	10.00	5.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**46.00**	**30.00**	**47.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	41%	57%	2%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	2%	41%	57%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	66%	34%
Physical effort required	0%	34%	66%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	55%	45%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	4%	21%	50%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	4%	17%	79%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	38%	54%
Physical effort required	0%	17%	83%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	4%	8%	88%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

For CPT 2023, the home and domiciliary E/M codes will be revised to delete codes 99324-99328, 99334-99337, 99343 and revise codes 99341, 99342, 99344, 99345, 99347-99350 to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance abuse treatment facilities. These changes include combining the domiciliary and rest home codes with the home visit codes so there is now a single code that describes

these types of visits. In addition, the descriptors were revised to allow reporting that is based on medical decision making or time alone—similar to the office/outpatient visit codes.

The following societies participated in surveying the revised codes: American Geriatrics Society, American Nurses Association, American Podiatric Medical Association (only 99341, 99342, 99347, 99348), and the American Academy of Home Care Medicine

Survey Analysis

The surveying societies established an expert panel that reviewed the survey data for all eight home visit codes. The expert panel noted that the key reference services chosen by respondents were typically office visit codes that had been revalued for CY 2021.

The expert panel determined that comparing the survey times to the current times would be inappropriate because the current intra-service times are simply the CPT times - they are not based on survey data. Therefore, the expert panel focused its review on comparing the survey times to other comparator codes.

In addition, the expert panel agreed that home visits are typically performed when patients are ill, cannot be seen in the office for a variety of health and socioeconomic situations and that typically they are more intense than office visits.

Recommendation - 99348

We recommend the survey 25th percentile work RVU of 1.50 and pre/intra/post times 7/29/10.

Key Reference Code Comparison

Code 99213 and survey code 99348 both involve low MDM, however, the intra-service time required for 99348 is 9 minutes (45%) greater than 99213 and the total time is 16 minutes (53%) greater than 99213, and therefore, code 99348 should be valued higher than 99213.

Code 99214 requires moderate complexity MDM compared with 99348 which requires low complexity MDM. Both codes require almost identical pre/intra/post-time.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.	**1.30**	0.054	0.043	30	5	20	5
99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.	**1.50**	**0.039**	**0.033**	**46**	**7**	**29**	**10**
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	**1.92**	0.051	0.041	47	7	30	10

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	**1.40**	0.065	0.050	28	5	18	5
99348	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.	**1.50**	**0.039**	**0.033**	**46**	**7**	**29**	**10**
99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant	**1.92**	0.049	0.038	50	10	30	10

Other Code Comparisons

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST

72195	Magnetic resonance (eg, proton) imaging, pelvis; without contrast material(s)	**1.46**	0.062	0.049	30	5	20	5
78491	Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study, at rest or stress (exercise or pharmacologic)	**1.56**	0.082	0.052	30	8	15	7

The expert panel agrees that the survey 25th percentile work RVU of 1.50 places 99348 in proper rank order to the key reference, MPC and other reference codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99335, 99348

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty podiatry How often? Commonly

Specialty nurse practitioner How often? Commonly

Specialty geriatric medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
1,737,978 If this is a recommendation from multiple specialties please estimate frequency and percentage for each

specialty. Please explain the rationale for this estimate. 2019 Medicare data for codes 99335 and 99348 - see specialty distribution for each code on the last page

Specialty Podiatry Frequency 337855 Percentage 19.43 %

Specialty Internal Medicine Frequency 278336 Percentage 16.01 %

Specialty Nurse Practioner Frequency 648539 Percentage 37.31 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99348

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99335 Claims = 1,241,609

NURSE PRACTITIONER	41.0%
INTERNAL MEDICINE	17.7%
FAMILY MEDICINE	13.1%
PODIATRY	11.1%
PHYSICIANS ASSISTANT	5.8%
PSYCHIATRY	3.7%
GERIATRIC MEDICINE	2.2%
GENERAL PRACTICE	1.9%
CERTIFIED CLINICAL NURSE SPECIALIST	0.7%
NEPHROLOGY	0.3%
EMERGENCY MEDICINE	0.3%
HOSPITALIST	0.2%
OPTOMETRY	0.2%
GERIATRIC PSYCHIATRY	0.2%
CARDIOLOGY	0.2%
PHYSICAL MEDICINE AND REHABILITATION	0.2%
DERMATOLOGY	0.1%

GENERAL SURGERY	0.1%
NEUROLOGY	0.1%
GASTROENTEROLOGY	0.1%
PULMONARY DISEASE	0.1%

99348 Claims = 496,369

PODIATRY	40.3%
NURSE PRACTITIONER	28.1%
INTERNAL MEDICINE	11.8%
FAMILY MEDICINE	8.8%
PHYSICIANS ASSISTANT	3.2%
GENERAL PRACTICE	2.6%
GERIATRIC MEDICINE	1.1%
PSYCHIATRY	0.8%
PLASTIC AND RECONSTRUCTIVE SURGERY	0.7%
GENERAL SURGERY	0.4%
EMERGENCY MEDICINE	0.4%
CERTIFIED CLINICAL NURSE SPECIALIST	0.3%
OPTOMETRY	0.2%
CARDIOLOGY	0.2%
HOSPICE AND PALLIATIVE CARE	0.2%
NEPHROLOGY	0.1%
NEUROLOGY	0.1%
GERIATRIC PSYCHIATRY	0.1%
HOSPITALIST	0.1%
HEMATOLOGY/ONCOLOGY	0.1%
PHYSICAL MEDICINE AND REHABILITATION	0.1%
PULMONARY DISEASE	0.1%
OBSTETRICS/GYNECOLOGY	0.1%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99349 Tracking Number J7 Original Specialty Recommended RVU: **2.70**
Presented Recommended RVU: **2.44**
Global Period: XXX Current Work RVU: **2.33** RUC Recommended RVU: **2.44**

CPT Descriptor: Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Home or residence visit for an established patient with a progressing illness or acute injury that requires medical management or potential surgical treatment.

Percentage of Survey Respondents who found Vignette to be Typical: 87%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review interval correspondence, referral notes, and/or medical records generated since the last home or residence service. Coordinate with other members of the health care team regarding the home or residence service.

Description of Intra-Service Work: Confirm patient's identity. Review prior clinical notes. Obtain vital signs. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan requiring moderate complexity medical decision making [MDM]. Discuss the treatment plan with patient and/or family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write orders, as necessary, for diagnostic imaging, labs, tests and/or therapeutic intervention(s). [Note: This service is provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship). A residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.]

Description of Post-Service Work: Document the encounter in the medical record. Communicate imaging/labs/test results and additional care plans to other health care professionals and to the patient and/or family/caregiver .Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver and respond to treatment failures.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Audrey Chun, MD; Michael Perskin, MD; Korinne, Van Keuren, DNP, APRN; Elisabeth Volpert, DNP, APRN					
Specialty Society(ies):	American Geriatrics Society, American Nurses Association, and the American Academy of Home Care Medicine.					
CPT Code:	99349					
Sample Size:	7719	**Resp N:**	76			
Description of Sample:	Random and use of the Medicare Claims data to identify additional survey participants, this method was review and approved by research subcommittee.					
		Low	**25th pctl**	**Median***	**75th pctl**	**High**
Service Performance Rate		0.00	0.00	**20.00**	143.00	1841.00
Survey RVW:		0.20	2.44	**2.70**	3.05	45.00
Pre-Service Evaluation Time:				**12.00**		
Pre-Service Positioning Time:				**0.00**		
Pre-Service Scrub, Dress, Wait Time:				**0.00**		
Intra-Service Time:		5.00	30.00	**41.00**	45.00	75.00
Immediate Post Service-Time:	**15.00**					
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**				
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**				
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**				
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**				
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**				
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**				
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**				

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99349	**Recommended Physician Work RVU: 2.44**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**12.00**	**0.00**	**12.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**41.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**15.00**	**0.00**	**15.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99214	XXX	1.92	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
75635	XXX	2.40	**RUC Time**	114,472

CPT Descriptor 1 Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99215	XXX	2.80	**RUC Time**	10,388,878

CPT Descriptor 2 Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 33 **% of respondents:** 43.4 **%**

Number of respondents who choose 2nd Key Reference Code: 24 **% of respondents:** 31.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 99349	Top Key Reference CPT Code: 99214	2nd Key Reference CPT Code: **99215**
Median Pre-Service Time	12.00	7.00	10.00
Median Intra-Service Time	41.00	30.00	45.00
Median Immediate Post-service Time	15.00	10.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**68.00**	**47.00**	**70.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	9%	73%	18%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	21%	79%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	42%	58%
Physical effort required	0%	21%	79%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	15%	85%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	4%	4%	0%	67%	25%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	8%	8%	84%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	4%	33%	63%
Physical effort required	0%	20%	80%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	4%	87%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

For CPT 2023, the home and domiciliary E/M codes will be revised to delete codes 99324-99328, 99334-99337, 99343 and revise codes 99341, 99342, 99344, 99345, 99347-99350 to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance abuse treatment facilities. These changes include combining the domiciliary and rest home codes with the home visit codes so there is now a single code that describes these types of visits. In addition, the descriptors were revised to allow reporting that is based on medical decision making or time alone—similar to the office/outpatient visit codes.

The following societies participated in surveying the revised codes: American Geriatrics Society, American Nurses Association, American Podiatric Medical Association (only 99341, 99342, 99347, 99348), and the American Academy of Home Care Medicine.

Survey Analysis

The surveying societies established an expert panel that reviewed the survey data for all eight home visit codes. The expert panel noted that the key reference services chosen by respondents were typically office visit codes that had been revalued for CY 2021.

The expert panel determined that comparing the survey times to the current times would be inappropriate because the current intra-service times are simply the CPT times - they are not based on survey data. Therefore, the expert panel focused its review on comparing the survey times to other comparator codes.

In addition, the expert panel agreed that home visits are typically performed when patients are ill, cannot be seen in the office for a variety of health and socioeconomic situations and that typically they are more intense than office visits.

Recommendation - 99349

We recommend the survey 25th percentile work RVU of 2.44 and pre/intra/post times 12/41/15.

There were 76 respondents of whom 87% found the vignette to be typical. The survey times were 12/41/15/68 and the median and 25th percentile work RVUs were 2.70 and 2.44 respectively.

Key Reference Code Comparison

Code 99214 involves moderate MDM similar to survey code 99349, however, the intra-service time required for 99314 is 11 minutes greater than 99214 and the total time is 21 minutes greater than 99214, and therefore, code 99349 should be valued higher than 99214.

Code 99215 requires the slightly more intra-service and total time compared with 99349. However, 99214 involves high complexity MDM. Therefore, the expert panel believes that 99349 should be valued less than 99215.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.	**1.92**	0.051	0.041	47	7	30	10
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.	**2.44**	**0.045**	**0.036**	**68**	**12**	**41**	**15**
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	**2.80**	0.050	0.040	70	10	45	15

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast	**2.40**	**0.051**	**0.042**	**57**	**10**	**39**	**8**

	material(s), including noncontrast images, if performed, and image postprocessing							
99349	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.	**2.44**	**0.045**	**0.036**	**68**	**12**	**41**	**15**
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	**2.80**	0.050	0.040	70	10	45	15

Other Code Comparisons

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
75635	Computed tomographic angiography, abdominal aorta and bilateral iliofemoral lower extremity runoff, with contrast material(s), including noncontrast images, if performed, and image postprocessing	**2.40**	0.051	0.042	57	10	39	8
95718	Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report, 2-12 hours of EEG recording; with video (VEEG)	**2.50**	0.059	0.045	55	10	35	10

The expert panel agrees that the survey 25th percentile work RVU of 2.44 places 99349 in proper rank order to the key reference, MPC and other reference codes.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99336, 99349

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty NURSE PRACTITIONER How often? Commonly

Specialty FAMILY MEDICINE How often? Sometimes

Specialty INTERNAL MEDICINE How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period?
2,829,152 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare data for codes 99336, 99349 - see specialty distribution for each code on the last page

Specialty Internal medicine Frequency 483678 Percentage 17.09 %

Specialty Family Medicine Frequency 372415 Percentage 13.16 %

Specialty Nurse Practioner Frequency 1425785 Percentage 50.39 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99349

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99336 Claims = 1,676,057

NURSE PRACTITIONER	50.6%
INTERNAL MEDICINE	17.3%

FAMILY MEDICINE	11.9%
PHYSICIANS ASSISTANT	8.8%
GENERAL PRACTICE	2.1%
GERIATRIC MEDICINE	2.1%
PODIATRY	1.8%
PSYCHIATRY	1.7%
EMERGENCY MEDICINE	0.5%
CERTIFIED CLINICAL NURSE SPECIALIST	0.5%
OPTOMETRY	0.4%
CARDIOLOGY	0.3%

99349 Claims – 1,153,095

NURSE PRACTITIONER	50.1%
INTERNAL MEDICINE	16.8%
FAMILY MEDICINE	15.0%
PHYSICIANS ASSISTANT	5.8%
GENERAL PRACTICE	3.5%
PODIATRY	3.0%
GERIATRIC MEDICINE	1.4%
EMERGENCY MEDICINE	0.5%
CARDIOLOGY	0.4%
GENERAL SURGERY	0.3%
NEPHROLOGY	0.3%
CERTIFIED CLINICAL NURSE SPECIALIST	0.3%
OPTOMETRY	0.3%

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99350 Tracking Number J8 Original Specialty Recommended RVU: **3.55**
Presented Recommended RVU: **3.50**
Global Period: XXX Current Work RVU: **3.28** RUC Recommended RVU: **3.60**

CPT Descriptor: Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: Home or residence visit for an established patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.

Percentage of Survey Respondents who found Vignette to be Typical: 86%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review interval correspondence, referral notes, and/or medical records generated since the last home or residence service. Coordinate with other members of the health care team regarding the home or residence service.

Description of Intra-Service Work: Confirm patient's identity. Review prior clinical notes. Obtain vital signs. Obtain a medically appropriate history. Update pertinent components of HPI, review of systems, social history, family history, and allergies, and reconcile the patient's medications. Perform a medically appropriate examination. Synthesize all the information, the relevant history and physical examination to formulate a differential diagnosis and treatment plan requiring high complexity medical decision making [MDM]. Discuss the treatment plan with patient and/or family/caregiver. Provide patient education and respond to questions from the patient and/or family/caregiver. Write orders, as necessary, for diagnostic imaging, labs, tests and/or therapeutic intervention(s). [Note: This service is provided in a home or residence. Home may be defined as a private residence, temporary lodging, or short term accommodation (eg, hotel, campground, hostel, or cruise ship). A residence is an assisted living facility, group home (that is not licensed as an intermediate care facility for individuals with intellectual disabilities), custodial care facility, or residential substance abuse treatment facility.]

Description of Post-Service Work: Document the encounter in the medical record. Communicate imaging/labs/test results and additional care plans to other health care professionals and to the patient and/or family/caregiver .Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates. Answer follow-up questions from patient and/or family/caregiver and respond to treatment failures.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021					
Presenter(s):	Audrey Chun, MD; Michael Perskin, MD; Korinne, Van Keuren, DNP, APRN; Elisabeth Volpert, DNP, APRN					
Specialty Society(ies):	American Geriatrics Society, American Nurses Association, and the American Academy of Home Care Medicine.					
CPT Code:	99350					
Sample Size:	7719	**Resp N:**	75			
Description of Sample:	Random and use of the Medicare Claims data to identify additional survey participants, this method was review and approved by research subcommittee.					

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**8.00**	33.00	1000.00
Survey RVW:	0.20	3.10	**3.60**	4.00	65.00
Pre-Service Evaluation Time:			**17.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	7.00	45.00	**60.00**	65.00	120.00

Immediate Post Service-Time:	**20.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99350	**Recommended Physician Work RVU: 3.60**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**17.00**	**0.00**	**17.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**60.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**
Immediate Post Service-Time:	**20.00**	**0.00**	**20.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	0.00	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	0.00	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	0.00	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	0.00	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	0.00	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	0.00	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99215	XXX	2.80	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99205	XXX	3.50	**RUC Time**	2,923,626

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
90962	XXX	3.57	**RUC Time**	213,048

CPT Descriptor 2 End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 37 **% of respondents:** 50.0 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 17.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 99350	Top Key Reference CPT Code: 99215	2nd Key Reference CPT Code: **99205**
Median Pre-Service Time	17.00	10.00	14.00
Median Intra-Service Time	60.00	45.00	59.00
Median Immediate Post-service Time	20.00	15.00	15.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**97.00**	**70.00**	**88.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	8%	38%	54%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	0%	11%	89%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	2%	38%	60%
Physical effort required	0%	14%	86%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	3%	14%	83%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	8%	0%	15%	31%	46%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	15%	23%	62%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	8%	8%	84%
Physical effort required	0%	15%	85%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	8%	8%	84%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

For CPT 2023, the home and domiciliary E/M codes will be revised to delete codes 99324-99328, 99334-99337, 99343 and revise codes 99341, 99342, 99344, 99345, 99347-99350 to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance abuse treatment facilities. These changes include combining the domiciliary and rest home codes with the home visit codes so there is now a single code that describes these types of visits. In addition, the descriptors were revised to allow reporting that is based on medical decision making or time alone—similar to the office/outpatient visit codes.

The following societies participated in surveying the revised codes: American Geriatrics Society, American Nurses Association, American Podiatric Medical Association (only 99341, 99342, 99347, 99348), and the American Academy of Home Care Medicine.

Survey Analysis

The surveying societies established an expert panel that reviewed the survey data for all eight home visit codes. The expert panel noted that the key reference services chosen by respondents were typically office visit codes that had been revalued for CY 2021.

The expert panel determined that comparing the survey times to the current times would be inappropriate because the current intra-service times are simply the CPT times - they are not based on survey data. Therefore, the expert panel focused its review on comparing the survey times to other comparator codes.

In addition, the expert panel agreed that home visits are typically performed when patients are ill, cannot be seen in the office for a variety of health and socioeconomic situations and that typically they are more intense than office visits.

Recommendation - 99350

We recommend between the survey median and 25th percentile with a crosswalk to CPT 75959 work RVU of 3.50 and survey pre/intra/post times 17/60/20.

There were 76 respondents of whom 87% found the vignette to be typical. The survey times were 17/60/209/97 and the median and 25th percentile work RVUs were 3.60 and 3.10 respectively.

Key Reference Code Comparison

Code 99215 involves high MDM similar to survey code 99350, however, the intra-service time required for 99350 is 15 minutes greater than 99215 and the total time is 27 minutes greater than 99215, and therefore, code 99350 should be valued higher than 99215.

Code 99205 requires the slightly more intra-service and total time compared with 99350. We also offer a crosswalk to CPT 75959 and 99205.

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.	**2.80**	0.050	0.040	70	10	45	15
99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.	**3.60**	**0.046**	**0.037**	**97**	**17**	**60**	**20**
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	**3.50**	0.050	0.040	88	14	59	15

MPC Code Comparison

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST

99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.	**3.50**	0.050	0.040	88	14	49	15
99350	Home or residence visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.	**3.60**	**0.046**	**0.037**	**97**	**17**	**60**	**20**
90962	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month	**3.57**	0.051	0.051	70	0	70	0

Other Code Comparisons

CPT	DESCRIPTOR	RVW	IWPUT	WPUT	TOTAL TIME	PRE	INTRA	POST
50329	Backbench reconstruction of cadaver or living donor renal allograft prior to transplantation; ureteral anastomosis, each	**3.34**	0.074	0.074	45	0	45	0
75959	Placement of distal extension prosthesis(s) (delayed) after endovascular repair of descending thoracic aorta, as needed, to level of celiac origin, radiological supervision and interpretation	**3.50**	0.058	0.041	85	20	45	20

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99337, 99350

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty NURSE PRACTITIONER How often? Commonly

Specialty FAMILY MEDICINE How often? Sometimes

Specialty HOSPICE AND PALLIATIVE CARE How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period?
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. National frequency data not available

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 1,037,857 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare data for codes 99337, 99350 - see specialty distribution for each code on the last page

Specialty Internal Medicine Frequency 176136 Percentage 16.97 %

Specialty Family Medicine Frequency 91816 Percentage 8.84 %

Specialty Nurse Practitioner Frequency 512633 Percentage 49.39 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:
Home visit

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99350

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

99337 Claims = 547,337

NURSE PRACTITIONER	44.1%
INTERNAL MEDICINE	18.2%
HOSPICE AND PALLIATIVE CARE	8.4%
FAMILY MEDICINE	6.2%

HOSPITALIST	3.6%
PHYSICIANS ASSISTANT	2.6%
PSYCHIATRY	2.4%
GERIATRIC MEDICINE	2.1%
PHYSICAL MEDICINE AND REHABILITATION	1.9%
NEUROLOGY	1.8%
EMERGENCY MEDICINE	1.2%
HEMATOLOGY/ONCOLOGY	0.8%

99350 Claims – 490,520

NURSE PRACTITIONER	55.3%
INTERNAL MEDICINE	15.6%
FAMILY MEDICINE	11.8%
PHYSICIANS ASSISTANT	7.0%
GENERAL PRACTICE	3.2%
GERIATRIC MEDICINE	2.1%
GENERAL SURGERY	0.8%
EMERGENCY MEDICINE	0.7%
CARDIOLOGY	0.6%
NEPHROLOGY	0.5%
HOSPICE AND PALLIATIVE CARE	0.4%
CERTIFIED CLINICAL NURSE SPECIALIST	0.3%
PODIATRY	0.3%

REVISED 9-30-2021

Updated: 5/24/20225:31 PM

ISSUE: Home & Residence Services

TAB: 13

Source	CPT	Global	DESC	RUC Review Year	MDM	CPT Descriptor Time	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	FAC-obs 38	39	26	25	24	17	Office 15	14	13	12	11	Prolonged 54	55	56	57	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	SF	15-29	45	0.047	0.047			0.93			20	2					15			3																										
2nd REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	LOW	30-40	30	0.046	0.046			1.60			35	5					25			5																										
CURRENT	99341	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997	SF	20		0.033	0.028			1.01			36	6					20			10																										
SVY	99341	XXX	Home or residence visit for the evaluation and management of a new		SF		93	0.049	0.041	0.80	1.00	1.50	1.80	45.00	37	6			1	15	25	40	60	6																								0	0	1	4	500
REC	99341	XXX	H-R visit, New Pt, straightforward MDM					0.049	0.037			1.00			27	6					15			6																										
REF	95907	XXX	Nerve conduction studies; 1-2 studies	2012				0.037	0.029			1.00			35	10					15			10																										
REF	91111	XXX	Gastrointestinal tract imaging, intraluminal (eg, capsule	2016				0.031	0.026			1.00			38	5					18			15																										
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	LOW	30-40	52	0.046	0.046			1.60			35	5					25			5																										
2nd REF	99204	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	MOD	45-59	25	0.043	0.043			2.60			60	10					40			10																										
CURRENT	99342	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997	LOW	30		0.034	0.029			1.52			52	10					30			12																										
SVY	99342	XXX	Home or residence visit for the evaluation and management of		LOW		97	0.049	0.038	0.90	1.65	2.00	2.60	60.00	52	10			1	25	32	50	90	10																								0	0	1	10	1000
REC	99342	XXX	H-R visit, New Pt, low level MDM					0.038	0.032			1.65			52	10					32			10																										
REF	76873	XXX	Ultrasound, transrectal; prostate volume study for					0.029	0.026			1.55			60	20					30			10																										
REF	95924	XXX	Testing of autonomic nervous system function; combined					0.035	0.029			1.73			60	15					30			15																										
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	MOD	45-59	35	0.043	0.043			2.60			60	10					40			10																										
2nd REF	99205	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	High	60-74	24	0.040	0.040			3.50			88	14					59			15																										
CURRENT	99344	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997	MOD	60		0.041	0.034			3.38			100	15					60			25																										
CURRENT	99343D	XXX	Home visit for the evaluation and management of a new patient, which	4/2/1997	MOD	45		0.040	0.033			2.53			77	15					45			17																										
SVY	99344	XXX	Home or residence visit for the evaluation and management of		MOD		72	0.046	0.038	0.50	2.87	3.50	3.79	65.00	92	15			6	40	60	75	100	17																								1	5	10	35	209
REC	99344	XXX	H-R visit, New Pt, moderate MDM					0.036	0.031			2.87			92	15					60			17																										
REF	74712	XXX	Magnetic resonance (eg, proton) imaging, fetal,	2015				0.039	0.033			3.00			90	15					60			15																										
REF	75563	XXX	Cardiac magnetic resonance imaging for morphology and	2007				0.042	0.037			3.00			82	12					60			10																										
REF	95912	XXX	Nerve conduction studies; 11-12 studies	2015				0.039	0.033			3.00			90	15					60			15																										
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and	2019	High	60-74	35	0.040	0.040			3.50			88	14					59			15																										
2nd REF	99291	XXX	Critical care, evaluation and management of the critically ill	2005	High	30-74	18	0.096	0.064			4.50			70	15					40			15																										
CURRENT	99345	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997				0.041	0.034			4.09			120	15					75			30																										
SVY	99345	XXX	Home or residence visit for the evaluation and management of		High		72	0.038	0.032	0.20	3.88	4.00	4.50	75.00	126	25			8	55	74	90	120	27																								0	0	2	20	400
REC	99345	XXX	H-R visit, New Pt, high MDM					0.037	0.031			3.88			126	25					74			27																										
REF	95720	XXX	Electroencephalogram (EEG), continuous recording,	2018				0.062	0.051			3.86			75	10					55			10																										
REF	38240	XXX	Hematopoietic progenitor cell (HPC); allogeneic					0.044	0.033			4.00			120	30					60			30																										
1st REF	99212	XXX	Office or other outpatient visit for the evaluation and	2019	SF	10-19	36	0.044	0.044			0.70			16	2					11			3																										
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019	LOW	20-29	28	0.043	0.043			1.30			30	5					20			5																										
CURRENT	99347	XXX	Home visit for the evaluation and management of an established patient,	4/1/1997				0.044	0.033			1.00			30	5					15			10																										
SVY	99347	XXX	Home or residence visit for the evaluation and management of		SF		84	0.054	0.043	0.18	0.90	1.30	1.91	30.00	30	5			1	12	20	30	60	5																								0	0	3	10	700
REC	99347	XXX	H-R visit, Est. Pt, straightforward MDM					0.034	0.030			0.90			30	5					20			5																										
REF	78227	XXX	Hepatobiliary system imaging, including gallbladder when	2011				0.044	0.035			0.90			26	6					15			5																										
REF	93307	XXX	Echocardiography, transthoracic, real-time with	2016				0.046	0.037			0.92			25	5					15			5																										
1st REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019	LOW	20-29	44	0.043	0.043			1.30			30	5					20			5																										
2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019	MOD	30-39	24	0.041	0.041			1.92			47	7					30			10																										
CURRENT	99348	XXX	Home visit for the evaluation and management of an established patient,	4/1/1997				0.045	0.035			1.56			44	9					25			10																										
SVY	99348	XXX	Home or residence visit for the evaluation and management of		LOW		84	0.053	0.042	0.20	1.50	1.92	2.13	35.00	45.5	7			4	20	29	35	60	10																								0	0	5	30	1000
REC	99348	XXX	H-R visit, Est Pt, low level MDM					0.039	0.033			1.50			46	7					29			10																										
REF	72195	XXX	Magnetic resonance (eg, proton) imaging, pelvis;	2016				0.062	0.049			1.46			30	5					20			5																										
REF	78491	XXX	Myocardial imaging, positron emission tomography (PET),	2019				0.082	0.052			1.56			30	8					15			7																										
1st REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019	MOD	30-39	33	0.041	0.041			1.92			47	7					30			10																										

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI	AJ	AK	AL	AM	AN	AO	AP	AQ	AR	AS	AT	AU	AV	AW	AX
13					RUC		CPT Descriptor				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	FAC-inpt/same day							FAC-obs				Office					Prolonged				SURVEY EXPERIENCE				
14	Source	CPT	Global	DESC	Review Year	MDM	Time	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	91	92	33	32	31	38	39	26	25	24	17	15	14	13	12	11	54	55	56	57	MIN	25th	MED	75th	MAX
66	2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019	High	40-54	24	0.040	0.040			2.80			70	10					45			15																								
67	CURRENT	99349	XXX	Home visit for the evaluation and management of an established patient	4/1/1997				0.044	0.036			2.33			65	10					40			15																								
68	SVY	99349	XXX	Home or residence visit for the evaluation and management of		Mod		76	0.051	0.040	0.20	2.44	2.70	3.05	45.00	67.5	12			5	30	41	45	75	15																						0	0	20	143	1841
69	REC	99349	XXX	H-R visit, Est. Pt, moderate MDM					0.045	0.036			2.44			68	12					41			15																								
70	REF	75635	XXX	Computed tomographic angiography, abdominal aorta	2016				0.051	0.042			2.40			57	10					39			8																								
71	REF	95718	XXX	Electroencephalogram (EEG), continuous recording,	2018				0.059	0.045			2.50			55	10					35			10																								
72																																																	
73	1st REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019	High	40-54	37	0.040	0.040			2.80			70	10					45			15																								
74	2nd REF	99205	XXX	Office or other outpatient visit for the evaluation and	2019	High	60-74	13	0.040	0.040			3.50			88	14					59			15																								
75	CURRENT	99350	XXX	Home visit for the evaluation and management of an established patient	4/1/1997	Mod to High	60		0.033	0.030			3.28			110	15					75			20																								
76	CURRENT	99337	XXX	Domiciliary or rest home visit for the evaluation and management of an	2007	Mod to High	60		0.047	0.038			3.58			95	15					60			20																								
77	SVY	99350	XXX	Home or residence visit for the evaluation and management of		High		75	0.046	0.037	0.20	3.10	3.60	4.00	65.00	97	17			7	45	60	65	120	20																						0	0	10	40	1000
78	REC	99350	XXX	H-R visit, Est. Pt, high MDM					0.046	0.037			3.60			97	17					60			20																								
79	REF	75959	XXX	XRAY PLACE DIST EXT THOR AO	2005				0.058	0.041			3.50			85	20					45			20																								
80	REF	50329	XXX	Backbench reconstruction of cadaver or living donor renal	2004				0.074	0.074			3.34			45						45																								
81																																																	

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TAB: 13

Source	CPT	Global	DESC	RUC Review Year	MDM	CPT Descriptor Time	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE-TIME EVAL	PRE-TIME POSIT	PRE-TIME SDW	INTRA-TIME MIN	INTRA-TIME 25th	INTRA-TIME MED	INTRA-TIME 75th	INTRA-TIME MAX	IMMD POST	SURVEY EXPERIENCE MIN	SURVEY EXPERIENCE 25th	SURVEY EXPERIENCE MED	SURVEY EXPERIENCE 75th	SURVEY EXPERIENCE MAX
1st REF	99202	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	SF	15-29	45	0.047	0.047			0.93			20	2					15			3					
2nd REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	LOW	30-40	30	0.046	0.046			1.60			35	5					25			5					
CURRENT	99341	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997	SF	20		0.033	0.028			1.01			36	6					20			10					
SVY	99341	XXX	Home or residence visit for the evaluation and management of a new		SF		93	0.049	0.041	0.80	1.00	1.50	1.80	45.00	37	6			1	15	25	40	60	6	0	0	1	4	500
Physicians	99341	XXX	Home or residence visit for the evaluation and management of a new patient, which				56	0.041	0.035	0.80	1.18	1.60	1.80	4.00	46	8			1	20	30	40	60	8	0	0	1	4	100
Podiatrists	99341	XXX	Home or residence visit for the evaluation and management of a new patient, which				32	0.058	0.045	0.93	0.95	1.08	1.50	45.00	24	4			1	14	15	23	46	5	0	0	0	5	500
Nurse Practioners	99341	XXX	Home or residence visit for the evaluation and management of a new patient, which				5	0.052	0.040	2.00	2.30	3.00	3.00	3.00	75	15			45	45	45	60	60	15	0	0	0	0	0
REC	99341	XXX	H-R visit, New Pt, straightforward MDM					0.049	0.037			1.00			27	6					15			6					
1st REF	99203	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	LOW	30-40	52	0.046	0.046			1.60			35	5					25			5					
2nd REF	99204	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	MOD	45-59	25	0.043	0.043			2.60			60	10					40			10					
CURRENT	99342	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997	LOW	30		0.034	0.029			1.52			52	10					30			12					
SVY	99342	XXX	Home or residence visit for the evaluation and management of		LOW		97	0.049	0.038	0.90	1.65	2.00	2.60	60.00	52	10			1	25	32	50	90	10	0	0	1	10	1000
Physicians	99342	XXX	Home or residence visit for the evaluation and management of a new patient, which				57	0.046	0.038	0.90	1.80	2.20	2.60	4.50	58	10			1	25	38	50	90	10	0	0	0	10	300
Podiatrists	99342	XXX	Home or residence visit for the evaluation and management of a new patient, which				35	0.052	0.043	1.00	1.60	1.75	2.03	60.00	41	5			1	19	28	33	58	8	0	0	5	36	1000
Nurse Practioners	99342	XXX	Home or residence visit for the evaluation and management of a new patient, which				5	0.052	0.039	2.50	3.00	3.50	3.50	3.50	90	20			50	50	50	60	60	20	0	0	0	0	0
REC	99342	XXX	H-R visit, New Pt, low level MDM					0.038	0.032			1.65			52	10					32			10					
1st REF	99204	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	MOD	45-59	35	0.043	0.043			2.60			60	10					40			10					
2nd REF	99205	XXX	Office or other outpatient visit for the evaluation and management of a new	2019	High	60-74	24	0.040	0.040			3.50			88	14					59			15					
CURRENT	99344	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997	MOD	60		0.041	0.034			3.38			100	15					60			25					
CURRENT	99343D	XXX	Home visit for the evaluation and management of a new patient, which	4/2/1997	MOD	45		0.040	0.033			2.53			77	15					45			17					
SVY	99344	XXX	Home or residence visit for the evaluation and management of		MOD		72	0.046	0.038	0.50	2.87	3.50	3.79	65.00	92	15			6	40	60	75	100	17	1	5	10	35	209
Physicians	99344	XXX	Home or residence visit for the evaluation and management of a new patient, which				65	0.051	0.041	0.50	2.80	3.50	3.79	65.00	86	14			6	40	55	65	100	17	1	5	10	37	209
Nurse Practioners	99344	XXX	Home or residence visit for the evaluation and management of a new patient, which				7	0.034	0.030	3.00	3.00	3.55	4.00	4.00	120	25			46	68	75	78	80	20	1	1	4	10	200
REC	99344	XXX	H-R visit, New Pt, moderate MDM					0.036	0.031			2.87			92	15					60			17					
1st REF	99205	XXX	Office or other outpatient visit for the evaluation and	2019	High	60-74	35	0.040	0.040			3.50			88	14					59			15					
2nd REF	99291	XXX	Critical care, evaluation and management of the critically ill	2005	High	30-74	18	0.096	0.064			4.50			70	15					40			15					
CURRENT	99345	XXX	Home visit for the evaluation and management of a new patient, which	4/1/1997				0.041	0.034			4.09			120	15					75			30					
SVY	99345	XXX	Home or residence visit for the evaluation and management of		High		72	0.038	0.032	0.20	3.88	4.00	4.50	75.00	126	25			8	55	74	90	120	27	0	0	2	20	400
Physicians	99345	XXX	Home or residence visit for the evaluation and management of a new patient, which				64	0.039	0.032	0.20	3.81	4.00	4.50	75.00	125	25			8	53	74	90	120	26	0	0	5	21	400
Nurse Practioners	99345	XXX	Home or residence visit for the evaluation and management of a new patient, which				8	0.030	0.027	2.00	3.99	4.00	4.50	4.50	150	30			20	59	90	90	90	30	0	0	0	0	15
REC	99345	XXX	H-R visit, New Pt, high MDM					0.037	0.031			3.88			126	25					74			27					
1st REF	99212	XXX	Office or other outpatient visit for the evaluation and	2019	SF	10-19	36	0.044	0.044			0.70			16	2					11			3					
2nd REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019	LOW	20-29	28	0.043	0.043			1.30			30	5					20			5					
CURRENT	99347	XXX	Home visit for the evaluation and management of an established	4/1/1997				0.044	0.033			1.00			30	5					15			10					
SVY	99347	XXX	Home or residence visit for the evaluation and management of		SF		84	0.054	0.043	0.18	0.90	1.30	1.91	30.00	30	5			1	12	20	30	60	5	0	0	3	10	700
Physicians	99347	XXX	Home or residence visit for the evaluation and management of an established				63	0.054	0.043	0.18	1.00	1.30	1.50	30.00	30	5			1	12	20	26	45	5	0	0	0	10	700

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	AT	AU	AV	AW	AX
15					RUC Review Year	MDM	CPT Descriptor Time				RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	Source	CPT	Global	DESC				Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
59	Podiatrists	99347	XXX	Home or residence visit for the evaluation and management of an established				14	0.044	0.036	0.70	0.81	0.92	1.23	3.00	25.5	6			4	6	16	20	46	4	2	10	10	12	100
60	Nurse Practioners	99347	XXX	Home or residence visit for the evaluation and management of an established				7	0.045	0.037	1.90	1.97	2.50	3.00	3.00	67	10			12	38	45	53	60	12	5	5	5	10	10
61	REC	99347	XXX	H-R visit, Est. Pt, straightforward MDM					0.034	0.030			0.90			30	5					20			5					
62																														
63	1st REF	99213	XXX	Office or other outpatient visit for the evaluation and	2019	LOW	20-29	44	0.043	0.043			1.30			30	5					20			5					
64	2nd REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019	MOD	30-39	24	0.041	0.041			1.92			47	7					30			10					
65	CURRENT	99348	XXX	Home visit for the evaluation and management of an established	4/1/1997				0.045	0.035			1.56			44	9					25			10					
66	SVY	99348	XXX	Home or residence visit for the evaluation and management of		LOW		84	0.053	0.042	0.20	1.50	1.92	2.13	35.00	45.5	7			4	20	29	35	60	10	0	0	5	30	1000
67	Physicians	99348	XXX	Home or residence visit for the evaluation and management of an established				66	0.063	0.047	0.20	1.60	1.95	2.10	35.00	41.5	7			4	20	25	35	60	10	0	0	10	38	1000
68	Podiatrists	99348	XXX	Home or residence visit for the evaluation and management of an established				12	0.048	0.041	0.80	1.40	1.50	1.76	2.20	36.5	6			7	12	27	30	58	5	0	0	0	38	500
69	Nurse Practioners	99348	XXX	Home or residence visit for the evaluation and management of an established				6	0.049	0.038	2.00	2.30	3.20	3.50	3.50	84	10			45	50	50	58	60	24	0	0	0	1	5
70	REC	99348	XXX	H-R visit, Est Pt, low level MDM					0.039	0.033			1.50			46	7					29			10					
71																														
72	1st REF	99214	XXX	Office or other outpatient visit for the evaluation and	2019	MOD	30-39	33	0.041	0.041			1.92			47	7					30			10					
73	2nd REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019	High	40-54	24	0.040	0.040			2.80			70	10					45			15					
74	CURRENT	99349	XXX	Home visit for the evaluation and management of an established	4/1/1997				0.044	0.036			2.33			65	10					40			15					
75	SVY	99349	XXX	Home or residence visit for the evaluation and management of		Mod		76	0.051	0.040	0.20	2.44	2.70	3.05	45.00	67.5	12			5	30	41	45	75	15	0	0	20	143	1841
76	Physicians	99349	XXX	Home or residence visit for the evaluation and management of an established				68	0.051	0.040	0.20	2.40	2.65	3.00	45.00	66.5	11			5	30	41	45	75	15	0	0	25	150	1841
78	Nurse Practioners	99349	XXX	Home or residence visit for the evaluation and management of an established				8	0.037	0.031	2.30	2.58	2.98	4.00	4.00	94.5	15			15	53	60	63	70	20	0	0	0	0	600
79	REC	99349	XXX	H-R visit, Est. Pt, moderate MDM					0.045	0.036			2.44			68	12					41			15					
80																														
81	1st REF	99215	XXX	Office or other outpatient visit for the evaluation and	2019	High	40-54	37	0.040	0.040			2.80			70	10					45			15					
82	2nd REF	99205	XXX	Office or other outpatient visit for the evaluation and	2019	High	60-74	13	0.040	0.040			3.50			88	14					59			15					
83	CURRENT	99350	XXX	Home visit for the evaluation and management of an established	4/1/1997	Mod to High	60		0.033	0.030			3.28			110	15					75			20					
84	CURRENT	99337	XXX	Domiciliary or rest home visit for the evaluation and management of an	2007	Mod to High	60		0.047	0.038			3.58			95	15					60			20					
85	SVY	99350	XXX	Home or residence visit for the evaluation and management of an established patient, which		High		75	0.046	0.037	0.20	3.10	3.60	4.00	65.00	97	17			7	45	60	65	120	20	0	0	10	40	1000
86	Physicians	99350	XXX	Home or residence visit for the evaluation and management of an established				67	0.046	0.037	0.20	3.10	3.60	4.00	65.00	97	17			7	43	60	63	120	20	0	0	10	45	1000
88	Nurse Practioners	99350	XXX	Home or residence visit for the evaluation and management of an established				8	0.034	0.029	2.60	3.18	3.55	4.50	4.50	121	20			28	68	75	80	80	26	0	0	0	0	100
89	REC	99350	XXX	H-R visit, Est. Pt, high MDM					0.046	0.037			3.60			97	17					60			20					
90																														

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350
SPECIALTY SOCIETY(IES): American Academy of Home Care Medicine, American Geriatrics Society, American Nurses Association, American Podiatric Medical Association (99341, 99342, 99348, 99349 only)
PRESENTER(S): Audrey Chun, MD (AGS), Michael Perskin, MD (AGS), Korinne Van Keuren, DNP, APRN (ANA), Elizabeth Volpert, DNP, APRN (ANA), Brooke Bisbee, DPM (APMA)

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: 04/2021 Tab 13
Home and Residence
REVISED 10-6-2021

CPT Code	Long Descriptor	Global Period
▲99341	Home or residence visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **straightforward** medical decision making.	XXX
▲99342	Home or residence visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **low** level of medical decision making.	XXX
▲99344	Home or residence visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **moderate** level of medical decision making.	XXX
▲99345	Home or residence visit for the evaluation and management of a **new** patient, which requires a medically appropriate history and/or examination and **high** level of medical decision making.	XXX
▲99347	Home or residence visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination **straightforward** medical decision making.	XXX
▲99348	Home or residence visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **low** level of medical decision making.	XXX
▲99349	Home or residence visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **moderate** level of medical decision making.	XXX
▲99350	Home or residence visit for the evaluation and management of an **established** patient, which requires a medically appropriate history and/or examination and **high** level of medical decision making.	XXX

Vignette(s) (*vignette required even if PE only code(s)*)**:**

CPT Code	Vignette
▲99341	Home or residence visit for a new patient with a self-limited problem.
▲99342	Home or residence visit for a new patient with an acute uncomplicated illness or injury.
▲99344	Home or residence visit for a new patient with a progressing illness or acute injury that requires diagnostic evaluation, medical management, or potential surgical treatment.
▲99345	Home or residence visit for a new patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.
▲99347	Home or residence visit for an established patient with an uncomplicated illness or injury.
▲99348	Home or residence visit for an established patient with a stable chronic illness or acute uncomplicated injury.
▲99349	Home or residence visit for an established patient with a progressing illness or acute injury that requires medical management or potential surgical treatment.
▲99350	Home or residence visit for an established patient with a chronic illness with severe

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

	exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

The joint societies met via email and zoom meeting as an expert panel to make recommendations. The RUC and PE survey tool did have an extensive survey component for PE. Of note, our experts believe combining these two in one link did complicate our ability to obtain the required number of completed surveys for the April 2021 meeting. The joint societies did review all the final data, using as a model, the E/M format analysis for outpatient PE survey. Specifically, to consider first median total times and to accept supplies where the data supported more than 50%, as a final step they confirmed the recommendation from their experiences. Of note, we did clarify during our virtual presentation for PE, our recommendations were derived from survey data first, then confirmed by expert panel.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code, but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (*for service reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

Current codes are used as reference plus compare to E/M outpatient visit code 99213

3. Is this code(s) typically reported with an E/M service?
Is this code(s) typically reported with the E/M service in the nonfacility?
(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

No
No
We did supply a detailed billed together list identifying, CPT 99341, 99342, 99344 and 99347 would typically have a procedure performed on the SDOS. For those CPT services we removed supplies that would be duplicative, such as gloves, alcohol wipes, booklet and tongue depressor.

4. What specialty is the dominant provider in the nonfacility?
What percent of the time does the dominant provider provide the service(s) in the nonfacility?
Is the dominant provider in the nonfacility different than for the global?
(Please see provided data titled *Medicare Same Day NF EM Billed Together - NF Dom Spec* in the RUC Review Resource Materials)

	Dominant	% NF	Different than global?
▲99341	podiatry	88%	no
▲99342	podiatry	77%	no
▲99344	nurse practitioner	52%	no
▲99345	nurse practitioner	55%	no
▲99347	podiatry	72%	no
▲99348	podiatry	40%	no
▲99349	nurse practitioner	50%	no
▲99350	nurse practitioner	55%	no

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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

5. If you are recommending more minutes than the PE Subcommittee standards for clinical activities you must provide rationale to justify the time:

n/a

6. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment and supplies for the **code family**, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

n/a

7. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

CA008 *perform regulatory mandated quality assurance,* historically contained 6 minutes (two phone calls) in total across this family of home visit services. This PE input was from prior crosswalks of older inputs. With todays updated PE options, a more accurate representation of the services is CA005 *complete pre procedure phone calls and prescription* and CA048 *identify need for x-rays, labs other test results,* therefore the six minutes were split into three for each of these across the family of codes. It was discussed during the presentation that both of these calls are necessary for each of the codes and if there was typically a procedure, then time would be removed from the procedure not from the visit. Similarly, for post services, CA038 *Coordinate post procedure services* which contained 6 minutes was divided 3 minutes to be retained and 3 minutes to be placed in CA037 *Conduct patient communications* across the family.

8. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

9. Please provide a brief description of the clinical staff work for the following:
   a. Pre-Service period:

Determine/gather test results, confirm by telephone patient visit, examples, X-rays (foot, chest, etc). Preparation for a home visit includes confirmation of arrival time and discussion for moving or removing Pets, any other items the provider needs to be aware of regarding access to location as well as, providing clear access to the patient.

   b. Service period (includes pre, intra and post):

   c. Post-service period:

-follow up calls to pharmacies, other offices for testing, follow up appointment etc.
-the staff calls patient next day- especially if a debridement was done - to check the dressing and/or make sure the patient/family doesn't have new questions on how to change the dressing or any other home instructions that the physician/QHP gave during visit.
- follow up calls post visit occur, for a home visit there are typically caregivers/family members, and the call would be to confirm understanding of next steps as well as answer both patient and

caregivers/family additional questions, which are common and typical.

10. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

N/A

11. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

12. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet workbook*):

N/A

13. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

INVOICES

14. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

15. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

16. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet workbook*) please provide a paid invoice. Identify and explain the invoice here:

N/A

17. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A

18. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

N/A

19. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet workbook*) please provide a paid invoice and the useful life. Identify and explain the invoice here:

N/A

20. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A

21. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

N/A

22. If there is any other item(s) on your spreadsheet not covered in the categories above that require greater detail/explanation, please include here:

N/A

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

23. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business the same day that the tab is reviewed. On the PE spreadsheet, please highlight the cells and/or use red font to show the changes made during the PE Subcommittee meeting (if you have provided any of this highlighting based on changes from the reference code prior to the PE Subcommittee meeting please remove it, so not to be confused with changes made during the meeting). In addition to those revisions please also provide an itemized list of the modifications made to

NONFACILITY DIRECT PE INPUTS

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AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

The following supplies were removed from all home established codes regardless of, if they were typically preformed with a procedure or not. The PE committee stated they did not believe they would be necessary on established patient home visits.
SM025 specula tip, otoscope
SK062 patient education booklet
SJ061 tongue depressor
The PE committee also removed 3 minutes for the phone call for CA038 for only CPT 99347.

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated and resubmitted asap.

	A	B	D	E	F	M	N	S	T	AC	AD
1	**RUC Practice Expense Spreadsheet**					**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2					**PATIENT ->**	**NEW**		**NEW**		**NEW**	
3					**MDM ->**	**straightforward**		**low**		**moderate**	
4						**99341**		**99342**		**99344**	
5						Typ Billed w/ Procedure SDOS		Typ Billed w/ Procedure SDOS		Typ Billed w/ Procedure SDOS	
6	**Clinical Activity Code**	**Meeting Date: 10/2021** **Revision Date (if applicable): 10/6/2021** **Tab: 13 Home and Residence** **Specialty: APMA, AGS, ANA, AAHPM**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	Home or residence visit for the evaluation and management of a		Home or residence visit for the evaluation and management of a		Home or residence visit for the evaluation and management of a	
7		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
8		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
9		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
10		**TOTAL CLINICAL STAFF TIME**	L037D			**12**	**0**	**12**	**0**	**12**	**0**
11		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**6**	**0**	**6**	**0**	**6**	**0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0**	**0**	**0**	**0**	**0**	**0**
13		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**6**	**0**	**6**	**0**	**6**	**0**
14		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
15		**PRE-SERVICE PERIOD**									
16		**Start: Following visit when decision for surgery/procedure made**									
17	CA001		L037D								
18	CA002		L037D								
19	CA003		L037D								
20	CA004		L037D								
21	CA005		L037D			3		3		3	
22	CA006		L037D								
23	CA007		L037D								
24	CA008		L037D			0		0		0	
25	CA048		L037D			3		3		3	
31		**End: When patient enters office/facility for surgery/procedure**									
32		**SERVICE PERIOD**									
33		**Start: When patient enters office/facility for surgery/procedure:**									
34		**Pre-Service (of service period)**									
35	CA008		L037D								
36	CA009		L037D								
37	CA010		L037D								
38	CA011		L037D								
39	CA012		L037D								
40	CA013		L037D								
41	CA014		L037D								
42	CA015		L037D								
43	CA016		L037D								
51		**Intra-service (of service period)**									
60		*Other activity: please include short clinical description here and type*	L037D								
61		*Other activity: please include short clinical description here and type*	L037D								
62		**Post-Service (of service period)**									
63	CA022		L037D								
64	CA023		L037D								
65	CA024		L037D								
66	CA025		L037D								
67	CA026		L037D								
68	CA027		L037D								
69	CA028		L037D								
70	CA029		L037D								
71	CA030		L037D								
72	CA031		L037D								
73	CA032		L037D								
74	CA033		L037D								
75	CA034		L037D								
76	CA035		L037D								
77	CA036		L037D			**n/a**		**n/a**		**n/a**	
78	CA037		L037D								
79	CA049		L037D								
80	CA050		L037D								
81	CA051		L037D								
82	CA052		L037D								
86		**End: Patient leaves office/facility**									
87		**POST-SERVICE PERIOD**									
88		**Start: Patient leaves office/facility**									
89	CA037		L037D			3		3		3	
90	CA038		L037D			3		3		3	
91		***Office visits: List Number and Level of Office Visits***	**MINUTES**			**# visits**	**# visits**	**# visits**	**# visits**	**# visits**	**# visits**
97	CA039		L037D			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
98			L037D								
104		**End: with last office visit before end of global period**									

	A	B	D	E	F	M	N	S	T	AC	AD
1	**RUC Practice Expense Spreadsheet**					**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2					**PATIENT ->**	**NEW**		**NEW**		**NEW**	
3					**MDM ->**	**straightforward**		**low**		**moderate**	
4						**99341**		**99342**		**99344**	
5						Typ Billed w/ Procedure SDOS		Typ Billed w/ Procedure SDOS		Typ Billed w/ Procedure SDOS	
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7		**LOCATION**				**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
8		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
9		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
10		**TOTAL CLINICAL STAFF TIME**	L037D			**12**	**0**	**12**	**0**	**12**	**0**
11		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D			**6**	**0**	**6**	**0**	**6**	**0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D			**0**	**0**	**0**	**0**	**0**	**0**
13		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D			**6**	**0**	**6**	**0**	**6**	**0**
105	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**							
106		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
107	SB004					1		1		1	
108	SB022					0		0		0	
109	SJ053					0		0		2	
110	SJ061					0		0		1	
111	SK062					1		1		1	
112	SM025	specula tips, otoscope				0		0		1	
113	SA047										
114	SM022										
121											
122	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**						
123		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
124	EQ189			Office Visits							
125	EF048			Other Formula							
126	EF023			Office Visits							
127				Office Visits							

	A	B	AI	AJ	AO	AP	AU	AV	BA	BB	BG	BH
1	RUC Practice Expense Spreadsheet		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED		RECOMMENDED	
2			NEW		ESTABLISHED		ESTABLISHED		ESTABLISHED		ESTABLISHED	
3			high		straightforward		low		moderate		high	
4			99345		99347		99348		99349		99350	
5					Typ Billed w/ Procedure SDOS							
6	Clinical Activity Code	Meeting Date: 10/2021 Revision Date (if applicable): 10/6/2021 Tab: 13 Home and Residence Specialty: APMA, AGS, ANA, AAHPM	Home or residence visit for the evaluation and management of a		Home or residence visit for the evaluation and management of an		Home or residence visit for the evaluation and management of an		Home or residence visit for the evaluation and management of an		Home or residence visit for the evaluation and management of an	
7		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
8		GLOBAL PERIOD	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
9		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
10		TOTAL CLINICAL STAFF TIME	12	0	9	0	12	0	12	0	12	0
11		TOTAL PRE-SERVICE CLINICAL STAFF TIME	6	0	6	0	6	0	6	0	6	0
12		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0	0	0	0	0	0	0	0	0	0
13		TOTAL POST-SERVICE CLINICAL STAFF TIME	6	0	3	0	6	0	6	0	6	0
14		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15		PRE-SERVICE PERIOD										
16		Start: Following visit when decision for surgery/procedure made										
17	CA001											
18	CA002											
19	CA003											
20	CA004											
21	CA005		3		3		3		3		3	
22	CA006											
23	CA007											
24	CA008		0		0		0		0		0	
25	CA048		3		3		3		3		3	
31		End: When patient enters office/facility for surgery/procedure										
32		SERVICE PERIOD										
33		Start: When patient enters office/facility for surgery/procedure:										
34		Pre-Service (of service period)										
35	CA008											
36	CA009											
37	CA010											
38	CA011											
39	CA012											
40	CA013											
41	CA014											
42	CA015											
43	CA016											
51		Intra-service (of service period)										
60		*Other activity: please include short clinical description here and type*										
61		*Other activity: please include short clinical description here and type*										
62		Post-Service (of service period)										
63	CA022											
64	CA023											
65	CA024											
66	CA025											
67	CA026											
68	CA027											
69	CA028											
70	CA029											
71	CA030											
72	CA031											
73	CA032											
74	CA033											
75	CA034											
76	CA035											
77	CA036		n/a		n/a		n/a		n/a		n/a	
78	CA037											
79	CA049											
80	CA050											
81	CA051											
82	CA052											
86		End: Patient leaves office/facility										
87		POST-SERVICE PERIOD										
88		Start: Patient leaves office/facility										
89	CA037		3		3		3		3		3	
90	CA038		3		0		3		3		3	
91		*Office visits: List Number and Level of Office Visits*	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits	# visits
97	CA039		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
98												
104		End: with last office visit before end of global period										

	A	B	AI	AJ	AO	AP	AU	AV	BA	BB	BG	BH
1	**RUC Practice Expense Spreadsheet**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**		**RECOMMENDED**	
2			**NEW**		**ESTABLISHED**		**ESTABLISHED**		**ESTABLISHED**		**ESTABLISHED**	
3			**high**		**straightforward**		**low**		**moderate**		**high**	
4			**99345**		**99347**		**99348**		**99349**		**99350**	
5					Typ Billed w/ Procedure SDOS							
6	**Clinical Activity Code**	**Meeting Date: 10/2021** **Revision Date (if applicable): 10/6/2021** **Tab: 13 Home and Residence** **Specialty: APMA, AGS, ANA, AAHPM**	Home or residence visit for the evaluation and management of a		Home or residence visit for the evaluation and management of an		Home or residence visit for the evaluation and management of an		Home or residence visit for the evaluation and management of an		Home or residence visit for the evaluation and management of an	
7		**LOCATION**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**	**Non Fac**	**Facility**
8		**GLOBAL PERIOD**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**	**XXX**
9		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
10		**TOTAL CLINICAL STAFF TIME**	**12**	**0**	**9**	**0**	**12**	**0**	**12**	**0**	**12**	**0**
11		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	**6**	**0**	**6**	**0**	**6**	**0**	**6**	**0**	**6**	**0**
12		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
13		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	**6**	**0**	**3**	**0**	**6**	**0**	**6**	**0**	**6**	**0**
105	**Supply Code**	**MEDICAL SUPPLIES**										
106		**TOTAL COST OF SUPPLY QUANTITY x PRICE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
107	SB004		1		1		1		1		1	
108	SB022		1		0		1		1		1	
109	SJ053		2		0		2		2		2	
110	SJ061		1		0		0		0		0	
111	SK062		1		0		0		0		0	
112	SM025	specula tips, otoscope	1		0		0		0		0	
113	SA047											
114	SM022											
121												
122	**Equipment Code**	**EQUIPMENT**										
123		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
124	EQ189											
125	EF048											
126	EF023											
127												

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Screen: CMS Request – Final Rule for 2020

October 2021

Prolonged Service - on Date Other Than the Face-to-Face EM Service Without Direct Patient Contact – Tab 14

In September 2019, the CPT Editorial Panel added a new table to the CPT introductory language for Prolonged Services that illustrates the elements of all existing and new prolonged care services and how they are to be reported. This clarification was in response to a request from CMS in the July 2019 Proposed Rule for the 2020 Medicare Physician Payment Schedule. In this 2020 Proposed Rule, CMS also stated that the valuation of CPT codes 99358 and 99359 should be reviewed. In the Final Rule for 2020, CMS noted its belief that the CPT guidelines for 99358 and 99359 needed to be revised for clarity and finalized the proposal that CPT codes 99358-99359 would not be payable in association with office/outpatient Evaluation and Management (E/M) visits.

In January 2020, no specialty societies indicated an interest in surveying these services. In the Final Rule, CMS expressed ongoing concern and confusion with 99358 and 99359 and their guidelines, even in the wake of the CPT Editorial Panel's action in September 2019. Further, the specialty societies wanted to address questions and concerns that CMS has in this regard, so these prolonged service codes may be appropriately used in conjunction with the E/M office visit codes in 2021 and beyond, after needed CPT clarification. Therefore, the specialty societies recommended that these services be referred to CPT prior to a resurvey of these services. The RUC discussed this issue and recommended that CPT codes 99358 and 99359 be referred to the May 2020 CPT Editorial Panel to clarify how these services may be reported with other E/M services. In May 2020, the CPT Editorial Panel revised the existing Prolonged Service section to remove references to typical times to reflect the new total time definition for office visits. In October 2020, the RUC recommended that CPT codes 99358 and 99359 be referred to the CPT Editorial Panel for February 2021, to be examined and surveyed along with the other E/M services for the 2023 Medicare Physician Payment Schedule.

In February 2021, the CPT Editorial Panel (1) deleted Prolonged Service With Direct Patient Contact (Except with Office or Other Outpatient Services) subsection including codes 99354-99357; (2) revised the Prolonged Service Without Direct Patient Contact heading and guidelines; (3) revised the Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional Supervision guidelines; (4) revised the Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service heading and guidelines.

99358 ***Prolonged evaluation and management service before and/or after direct patient care; first hour***
The RUC reviewed the survey results from 61 physicians and other qualified healthcare professionals (QHP) and recommends the 25th percentile work RVU of 1.80 for CPT code 99358. The RUC recommends 50 minutes of intra-service and total time. The RUC noted that this time-based code should be reported by itself for between 30 minutes and 74 minutes of time on a date other than the face-to-face EM service without direct patient contact and noted that the survey median of 50 minutes appropriately falls just under the midpoint of that time range. The RUC noted that, although this is a non-face-to-face service, for a patient to require so much physician or other QHP time on a separate date before and/or after direct patient care, the patient would most typically be complex. This is reflected in 89 percent of the survey respondents indicating that the

following complex patient is typical: “An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. The physician or other qualified healthcare professional indicated that past medical records are needed from the patient's prior physicians or other qualified healthcare professionals, and they are reviewed upon arrival.” Although this service is not face-to-face, the specialties noted, and the RUC concurred, that this service has a moderate level of complexity, as it often involves reviewing records that are in disparate formats from the provider’s EMR system, clarifying test results and diagnoses, locating records, and understanding and interpreting imaging and diagnostic tests.

The RUC noted that the CPT parentheticals state that this service is not to be reported on the same date of service as codes 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99417, 99483 and 993X0. Also, the CPT introductory language specifically states the following: “If the prolonged service relates to an evaluation and management service that uses total time to select the service on the date of the encounter, the prolonged service without direct patient contact may not be reported. Prolonged service without direct patient contact may only be reported when it occurs on a date other than the date of the evaluation and management service.”

To justify a work RVU of 1.80, the RUC compared the surveyed code to the second key reference code 99204 *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.* (work RVU= 2.60, 60 minutes total time) and noted that the surveyed code involves 10 minutes less of intra-service time and the work per unit of time of the recommendation would be appropriately less than the face-to-face office visit reference code. The RUC also compared the surveyed code to CPT code 99214 *Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.* (work RVU= 1.92, 48 minutes total time) and noted that although both services involve a similar amount of time, the surveyed code is somewhat less intense to perform. The RUC noted that the work per unit of time of the recommendation would be appropriately less than the face-to-face office visit reference code. The RUC also compared the surveyed code to CPT code 93351 *Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation and report; including performance of continuous electrocardiographic monitoring, with supervision by a physician or other qualified health care professional* (work RVU=1.75 minutes, 40 minutes total time) and noted that although the surveyed code involves 10 minutes more total time, a similar value of 1.80 for the surveyed code would be appropriate as the surveyed code is a somewhat less intense service to perform. **The RUC recommends a work RVU of 1.80 for CPT code 99358.**

99359 ***Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)***

The RUC reviewed the survey results from 54 physicians and other qualified healthcare professionals (QHP) and recommends the 25th percentile work RVU of 0.75 for CPT code 99359. The RUC recommends 30 minutes of intra-service and total time for this add-on service. The RUC noted that the first unit of this time-based add-on code would be reported along with the base code if the prolonged service is between 75 minutes and 104 minutes and took these reporting rules into account when determining an appropriate relative value for this service. It was noted that this is a relatively very low volume service for an E/M code, with only 7,861 Medicare utilization in 2019. Although this service is not face-to-face, the specialties noted, and the RUC concurred, that this service has a moderate level of complexity as it often involves reviewing records that are in disparate formats from the provider's EMR system, clarifying test results and diagnoses, locating records, and understanding and interpreting imaging and diagnostic tests.

The RUC noted that the CPT parentheticals state that this service is not to be reported on the same date of service as codes 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99417, 99483 and 993X0. Also, the CPT introductory language specifically states the following: "If the prolonged service relates to an evaluation and management service that uses total time to select the service on the date of the encounter, the prolonged service without direct patient contact may not be reported. Prolonged service without direct patient contact may only be reported when it occurs on a date other than the date of the evaluation and management service."

To justify a work RVU of 0.75, the RUC compared the surveyed code to the second key reference code 99458 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)* (work RVU=0.61, intra-service and total time of 20 minutes) and noted that the surveyed code involves 10 more minutes of total time, justifying a higher value. The RUC also compared the surveyed code to CPT code 99498 *Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)* (work RVU=1.40, intra-service and total time of 30 minutes) and noted that the reference code is a more intense service to perform and that a value of 0.75 for the surveyed code would have appropriate relativity with this reference service. **The RUC recommends a work RVU of 0.75 for CPT code 99359.**

Practice Expense

The Practice Expense Subcommittee reviewed the direct practice expenses and made modifications to remove the equipment input ED021 *Computer, desktop, w-monitor* from codes 99358 and 99359 on the basis that this is an indirect expense. EQ189 *otoscope-ophthalmoscope (wall unit)* and EF023 *exam table* were also removed from the recommended inputs since the patient is not present for these services as they are not face to face. **The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee.**

Work Neutrality
The RUC's recommendation for this family of codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Prolonged Services** ~~**Prolonged Service With Direct Patient Contact (Except with Office or Other Outpatient Services)**~~ ~~Codes 99354-99357 are used when a physician or other qualified health care professional provides prolonged service(s) involving direct patient contact that is provided beyond the usual service in either the inpatient, observation or outpatient setting, except with office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Direct patient contact is face-to-face and includes additional non-face-to-face services on the patient's floor or unit in the hospital or nursing facility during the same session. This service is reported in addition to the primary procedure. Appropriate codes should be selected for supplies provided or other procedures performed in the care of the patient during this period.~~ ~~Codes 99354-99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service in the outpatient setting, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Codes 99356-99357 are used to report the total duration of time spent by a physician or other qualified health care professional at the bedside and on the patient's floor or unit in the hospital or nursing facility on a given date providing prolonged service to a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous.~~ ~~Time spent performing separately reported services other than the E/M or psychotherapy service is not counted toward the prolonged services time.~~ ~~Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service.~~ ~~Either code should be used only once per date, even if the time spent by the physician or other qualified health care professional is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported.~~ ~~Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. Either code may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.~~				

The use of the time based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook.

For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, use 99415, 99416. Do not report 99354, 99355 with 99415, 99416, 99417.

For prolonged total time in addition to office or other outpatient services (ie, 99205, 99215), use 99417.

The following table illustrates the correct reporting of prolonged physician or other qualified health care professional service with direct patient contact in the inpatient or observation setting beyond the usual service time.

Total Duration of Prolonged Services	**Code(s)**
less than 30 minutes	Not reported separately
30-74 minutes (30 minutes - 1 hr. 14 min.)	99356 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99356 X 1 AND 99357 X 1
105 or more (1 hr. 45 min. or more)	99356 X 1 AND 99357 X 2 or more for each additional 30 minutes.

+ 99354	-	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient **Evaluation and Management** or psychotherapy service) (Use 99354 in conjunction with 90837, 90847, 99241-99245, 99324-99337, 99341-99350, 99483) (Do not report 99354 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99415, 99416, 99417)	ZZZ	N/A

~~+99355~~	-	~~each additional 30 minutes (List separately in addition to code for prolonged service)~~ ~~(Use 99355 in conjunction with 99354)~~ ~~(Do not report 99355 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99415, 99416, 99417)~~	~~ZZZ~~	~~N/A~~
~~+99356~~	-	~~Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient **Evaluation and Management** service)~~ ~~(Use 99356 in conjunction with 90837, 90847, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310)~~	~~ZZZ~~	~~N/A~~
~~+99357~~	-	~~each additional 30 minutes (List separately in addition to code for prolonged service)~~ ~~(Use 99357 in conjunction with 99356)~~ (99354, 99355 have been deleted. For prolonged evaluation and management services on the date of an office or other outpatient service, home and residence service, or cognitive assessment and care plan, use 99417. For prolonged psychotherapy, use 908X0) (99356, 99357 have been deleted. For prolonged service on the date of an inpatient or observation or nursing facility service, use 993X0. For prolonged psychotherapy, use 908X0)	~~ZZZ~~	~~N/A~~

Prolonged Service on Date Other Than the Face-to-Face E/M Service Without Direct Patient Contact

Codes 99358 and 99359 are used when a prolonged service is provided ~~that is neither face-to-face time in the outpatient, inpatient, or observation setting, nor additional unit/floor time in the hospital or nursing facility setting. Codes 99358, 99359 may be used during the same session of an evaluation and management service, except office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). For prolonged total time in addition to office or other outpatient services (ie, 99205, 99215) on the same date of service without direct patient contact, use 99417. Codes 99358, 99359 may also be used for prolonged services~~ on a date other than the date of a face-to face evaluation and management encounter. Codes 99358, 99359 may be reported for prolonged services in relation to any evaluation and management service whether or not time was used to select the level of the face-to-face service.

This service is to be reported in relation to other physician or other qualified health care professional services, including evaluation and management services at any level. This prolonged service may be reported on a different date than the primary service to which it is related. If the prolonged service relates to an evaluation and management service that uses total time to select the service on the date of the encounter, the prolonged service without direct patient contact may not be reported. Prolonged service without direct patient contact may only be reported when it occurs on a date other than the date of the evaluation and management service. For example, extensive record review may relate to a previous evaluation and management service performed at an earlier date. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management.

Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99359 is used to report each additional 30 minutes beyond the first hour. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Do not report 99358, 99359 for time without direct patient contact reported in other services such as ~~and the Remote Physiologic code~~ care plan oversight services (99339, 99340, 99374-99380), chronic care management by a physician or other qualified health care professional (*99X21,* 99491), principal care management by a physician or other qualified health care professional (*99X22, 99X23, 99X24, 99X25*), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366-99368), interprofessional telephone/Internet/electronic health record consultations (99446, 99447, 99448, 99449, 99451, 99452), or online digital evaluation and management services (99421, 99422, 99423).

(f)99358	K1	Prolonged evaluation and management service before and/or after direct patient care; first hour	XXX	1.80
(f)✚99359	K2	each additional 30 minutes (List separately in addition to code for prolonged service) (Use 99359 in conjunction with 99358) ~~(Do not report 99358, 99359 on the same date of service as 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99417)~~ (Do not report 99358, 99359 on the same date of service as 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222,	ZZZ	0.75

99223, 99231, 99232, 99233, 99234, 99235, 99236, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99417, 99483, 993X0)

Total Duration of Prolonged Services Without Direct Face-to-Face Contact	**Code(s)**
less than 30 minutes	Not reported separately
30-74 minutes (30 minutes - 1 hr. 14 min.)	99358 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99358 X 1 AND 99359 X 1
105 or more (1 hr. 45 min. or more)	99358 X 1 AND 99359 X 2 or more for each additional 30 minutes.

~~**Comparison of Prolonged Services Codes 99354, 99355, 99356, 99357, 99358, 99359, 99417 Table**~~

Code	Patient Contact	Minimum Reportable Prolonged Services Time (Single Date of Service)	Use In Conjunction With	*Do Not Report With	Other Prolonged Service(s) Reportable On Same Date Of Service
+99354	Face-to-Face Only	30 minutes (Beyond listed typical time)	90837, 90847, 99241-99245, 99324-99337, 99341-99350, 99483	99202-99215, 99415, 99416, 99417	99358, 99359
+99355	Face-to-Face Only	Each additional 15 minutes (Beyond 99354)	99354	99202-99215, 99415, 99416, 99417	99358, 99359
+99356	Face-to-Face and Unit/ Floor Time	30 minutes (Beyond listed typical time)	90837, 90847, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310		99358, 99359
+99357	Face-to-Face and Unit/ Floor Time	Each additional 15 minutes (Beyond 99356)	99356		99358, 99359
99358	Non-Face-to-Face Only	30 minutes	Must relate to a service where face-to-face care has or will occur. This is not an add-on code and is not used in conjunction with a base code.	99202-99215, 99417 On same date of service	99354, 99356
+99359	Non-Face-to-Face Only	Each additional 15 minutes (Beyond 99358)	99358	99202-99215, 99417 On same date of service	99354, 99356

+99417	Both	Reported with 99205: 75 minutes or more Reported with 99215: 55 minutes or more ***(Total time on the date of encounter)***	99205, 99215	99354, 99355, 99358, 99359, 99415, 99416	N/A
*Do not count the time of any separately reported service as Prolonged Services time 99355 is for prolonged services time beyond 99354 and may be reported in multiple units 99357 is for prolonged services time beyond 99356 and may be reported in multiple units 99359 is for prolonged services time beyond 99358 and may be reported in multiple units 99417 is for prolonged services time beyond 99205 or 99215 and may be reported in multiple units of at least 15 minutes					

CPT 2023 E/M Guidelines

Category I
Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter. (For 99211 and 99281 the face-to-face services may be performed by clinical staff).

In the **Evaluation and Management** section (99202-99499) there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home and Residence Services
- Prolonged Service With or Without Direct Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office or other outpatient visit. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

The place of service and service type is defined by the location where the face-to-face encounter occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Coding Tip

Instructions for Use of the CPT Codebook

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialty as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his or her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional, and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specific professional service but does not individually report that professional service. Other policies may also affect who may report specific services.

CPT Coding Guidelines, Introduction, Instructions for Use of the CPT Codebook

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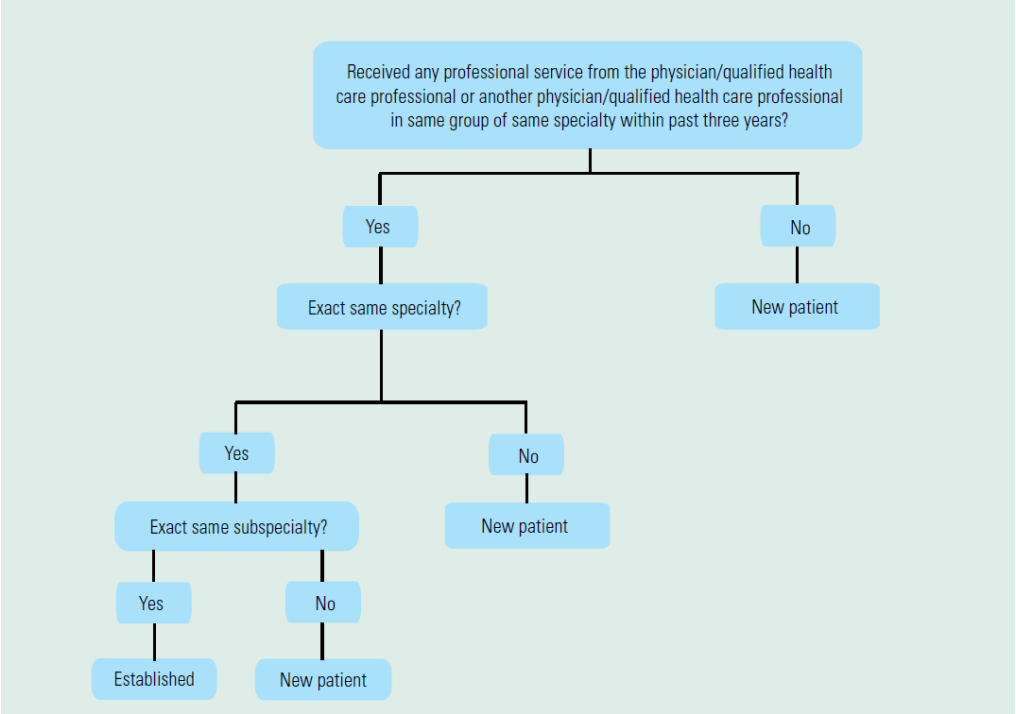
Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient or observation or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and subspecialty as the physician.

For reporting hospital inpatient or observation care services, a stay that includes a transition from observation to inpatient is a single stay. For reporting nursing facility services, a stay that includes transition(s) between skilled nursing facility and nursing facility level of care is the same stay.

Services Reported Separately

Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation

of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation and may be counted as ordered or reviewed for selecting an MDM level.

The performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

See Instructions for Selecting a Level Based on MDM or Time.

The physician or other qualified health care professional may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant separately identifiable E/M service. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date.

History and/or Examination

These E/M services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.

Levels of E/M Services

Select the appropriate level of E/M services based on the following:

1. The level of the MDM as defined for each service, **or**

2. The total time for E/M services performed on the date of the encounter.

Within each category or subcategory of E/M service based on MDM or time, there are three to five levels of E/M services available for reporting purposes. Levels of E/M services are **not** interchangeable among the different categories or subcategories of service. For example, the first level of E/M services in the subcategory of office visit, new patient, does not have the same definition as the first level of E/M services in the subcategory of office visit, established patient. Each level of E/M services may be used by all physicians or other qualified health care professionals.

Guidelines for Selecting a level service based on Medical Decision Making

Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211 or 99281.

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter***.
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported

separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to risk for a specific patient is not ordered. These considerations must be documented. Data are divided into three categories:

- Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
- Independent interpretation of tests (not separately reported)
- Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source (not separately reported)

- **The risk of complications and/or morbidity or mortality of patient management:** This includes decisions made at the encounter associated with the diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected, after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

Shared decision making involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options.

MDM may be impacted by role and management responsibility.

When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report is not counted toward the MDM when selecting a level of E/M services.

When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of E/M services.

The Levels of Medical Decision Making (MDM) table (Table 2) is a guide to assist in selecting the level of MDM for reporting an E/M services code. The table includes the four levels of MDM (ie, straightforward, low, moderate, high) and the three elements of MDM (ie, number and complexity of problems addressed at the encounter, amount and/or complexity of data reviewed and analyzed, and risk of complications and/or morbidity or mortality of patient management). To qualify for a particular level of MDM, two of the three elements for that level of MDM must be met or exceeded.

Examples in the table may be more or less applicable to specific settings of care. For example, the decision to hospitalize applies to the outpatient or nursing facility encounters, whereas the decision to escalate hospital level of care (eg, transfer to ICU) applies to the hospitalized or observation care patient.

See also the introductory guidelines of each code family section.

Table 2: Levels of Medical Decision Making (MDM)

Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
N/A	N/A	N/A	N/A
Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
Low	Low • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury or • 1 stable acute illness or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	Limited *(Must meet the requirements of at least 1 of the 2 categories*) Category 1: Tests and documents • Any combination of 2 from the following: ○ Review of prior external note(s) from each unique source*; ○ Review of the result(s) of each unique test*; ○ Ordering of each unique test* or Category 2: Assessment requiring an independent historian(s) *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatment

Moderate	Moderate
	• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
	or
	• 2 or more stable, chronic illnesses;
	or
	• 1 undiagnosed new problem with uncertain prognosis;
	or
	• 1 acute illness with systemic symptoms;
	or
	• 1 acute, complicated injury
		Moderate
		(Must meet the requirements of at least 1 out of 3 categories)
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			Moderate risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Prescription drug management
			• Decision regarding minor surgery with identified patient or procedure risk factors
			• Decision regarding elective major surgery without identified patient or procedure risk factors
			• Diagnosis or treatment significantly limited by social determinants of health

High	High
	• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
	or
	• 1 acute or chronic illness or injury that poses a threat to life or bodily function
		Extensive
		(Must meet the requirements of at least 2 out of 3 categories)
		
		Category 1: Tests, documents, or independent historian(s)
		• Any combination of 3 from the following:
		  ○ Review of prior external note(s) from each unique source*;
		  ○ Review of the result(s) of each unique test*;
		  ○ Ordering of each unique test*;
		  ○ Assessment requiring an independent historian(s)
		or
		Category 2: Independent interpretation of tests
		• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
		or
		Category 3: Discussion of management or test interpretation
		• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
			High risk of morbidity from additional diagnostic testing or treatment
			
			Examples only:
			• Drug therapy requiring intensive monitoring for toxicity
			• Decision regarding elective major surgery with identified patient or procedure risk factors
			• Decision regarding emergency major surgery
			• Decision regarding hospitalization or escalation of hospital-level of care
			• Decision not to resuscitate or to de-escalate care because of poor prognosis
			• Parenteral controlled substances

Number and Complexity of Problems Addressed at the Encounter

One element used in selecting the level of services is the number and complexity of the problems that are addressed at the encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities and underlying diseases, in and of themselves, are not considered in selecting a level of E/M services **unless** they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. Therefore, presenting symptoms which are likely to represent a highly morbid condition may drive MDM even when the ultimate diagnosis is not highly morbid. The evaluation and /or treatment should be consistent with the likely nature of the condition. Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.

The term "risk" as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.

Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) are:

Problem: *A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.*

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. For hospital inpatient and observation care services, the problem addressed is the problem status on the date of the encounter, which may be significantly different than on admission. It is the problem being managed or co-managed by the reporting physician or qualified health care professional and may not be the cause of admission or continued stay.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211, 99281).

Self-limited or minor problem: *A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.*

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness.

Acute, uncomplicated illness or injury requiring hospital inpatient or observation level care: A recent or new short-term problem with low risk of morbidity for which treatment is required. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. The treatment required is delivered in a hospital inpatient or observation level setting.

Stable, acute illness: A problem that is new or recent for which treatment has been initiated. The patient is improved and while resolution may not be complete is stable with respect to this condition.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, see the definitions for **self-limited or minor problem** or **acute, uncomplicated illness or injury.** Systemic symptoms may not be general but may be single system.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options are multiple and/or associated with risk of morbidity.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require escalation in level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Some symptoms may represent a condition that is significantly probable and poses a potential threat to life or bodily function. These may be included in this category when the evaluation and treatment is consistent with this degree of potential severity.

Amount and/or Complexity of Data to be Reviewed and Analyzed

One element used in selecting the level of services is the amount and/or complexity of data to be reviewed or analyzed at an encounter.

Analyzed: Analyzed is a term describing the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter where they are analyzed. In the case of a recurring order, each new result may be counted in the encounter at which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional

reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, only count one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified heath care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element towards MDM.

Combination of Data Elements: A combination of different data elements, for example a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: *External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.*

External physician or other qualified health care professional: *An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.*

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter but is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. It does not include translation services. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code, and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional who reports the E/M service is reporting or has previously reported the test. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: *For the purpose of the* ***discussion of management*** *data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.*

Risk of Complications and/or Morbidity or Mortality of Patient Management

One element used in selecting the level of services is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: *A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.*

Social determinants of health: *Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.*

Surgery (minor or major, elective, emergency, procedure or patient risk):

> ***Surgery-Minor or Major:*** The classification of surgery into minor or major is based upon the common meaning of such terms when used by trained clinicians, similar to the use of the term "risk". These terms are not defined by a surgical package classification.
>
> ***Surgery-Elective or Emergency:*** Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient's condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.
>
> ***Surgery-Risk Factors, Patient or Procedure:*** Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. An example may be monitoring for cytopenia in the use of an antineoplastic agent between dose cycles. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold.

Guidelines for Selecting Level of Service Based on Time

Certain categories of time-based E/M codes that do not have levels of services based on MDM (eg, Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) both provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The total time on the date of the encounter spent caring for the patient should be documented in the medical record when it is used as the basis for code selection.

Physician or other other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (when not separately reported) and communicating results to the patient family/caregiver
- care coordination (when not separately reported)

Do not count time spent on the following:

- the performance of other services reported separately

- travel
- teaching that is general and not limited to discussion that is required for the management of the specific patient

Unlisted Service

An E/M service may be provided that is not listed in this section of the CPT codebook. When reporting such a service, the appropriate unlisted code may be used to indicate the service, identifying it by "Special Report," as discussed in the following paragraph. The "Unlisted Services" and accompanying codes for the E/M section are as follows:

***99429 Unlisted preventive** medicine service*

***99499 Unlisted evaluation and management** service*

Special Report

An unlisted service or one that is unusual, variable, or new may require a special report demonstrating the medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99358 Tracking Number

Original Specialty Recommended RVU: **1.80**
Presented Recommended RVU: **1.80**
RUC Recommended RVU: **1.80**

Global Period: XXX Current Work RVU: **2.10**

CPT Descriptor: Prolonged evaluation and management service before and/or after direct patient care; first hour

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. The physician or other qualified healthcare professional indicated that past medical records are needed from the patient's prior physicians or other qualified healthcare professionals and they are reviewed upon arrival.

Percentage of Survey Respondents who found Vignette to be Typical: 89%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: (not applicable)

Description of Intra-Service Work: Continue or prepare for the work of face-to-face evaluation and management on a date of service different from that of the face-to-face evaluation and management. Spend 30 to 74 minutes in non-face-to-face tasks, such as extensive record review, review of imaging studies, discussions with other physicians and qualified healthcare professionals, and ongoing, disease-specific patient management.

Description of Post-Service Work: (not applicable)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021
Presenter(s):	Megan Adamson, MD; Elizabeth Blanchard, MD; Audrey Chun, MD; Omar Hussain, DO; Charles Hamori, MD, FACP; Kevin Kerber, MD; Steven Krug, MD; Stephen Lahey, MD; James Levett, MD; Kano Mayer, MD; Phillip E. Rodgers, MD, FAAHPM; Fredrica Smith, MD; Karin Swartz, MD; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Pediatrics, American Association for Thoracic Surgery, American College of Physicians, American College of Rheumatology, American Geriatrics Society, American Nurses Association, American Society of Clinical Oncology, American Thoracic Society, American College of Chest Physicians, North American Spine Society, Society of Thoracic Surgeons
CPT Code:	99358
Sample Size: 20981	**Resp N:** 61
Description of Sample:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	2.00	**8.00**	50.00	3500.00
Survey RVW:	0.50	1.80	**2.45**	3.50	28.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	30.00	**50.00**	60.00	90.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	99358	**Recommended Physician Work RVU: 1.80**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**50.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)
XXX Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99205	XXX	3.50	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99204	XXX	2.60	**RUC Time**

CPT Descriptor Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
93351	XXX	1.75	**RUC Time**	241,940

CPT Descriptor 1 Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, during rest and cardiovascular stress test using treadmill, bicycle exercise and/or pharmacologically induced stress, with interpretation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization

92004	XXX	1.82	**RUC Time**	2,208,242

CPT Descriptor 2 Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 25 **% of respondents:** 40.9 **%**

Number of respondents who choose 2nd Key Reference Code: 12 **% of respondents:** 19.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99358	**Top Key Reference CPT Code:** 99205	**2nd Key Reference CPT Code:** **99204**
Median Pre-Service Time	0.00	14.00	10.00
Median Intra-Service Time	50.00	59.00	40.00
Median Immediate Post-service Time	0.00	15.00	10.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**50.00**	**88.00**	**60.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	16%	32%	28%	24%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	12%	40%	48%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	20%	48%	32%
Physical effort required	16%	56%	28%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	20%	60%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	33%	42%	25%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	33%	33%	33%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	17%	75%	8%
Physical effort required	58%	42%	0%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	42%	42%	16%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Code 99358 describes "Prolonged evaluation and management service before and/or after direct patient care; first hour," and code 99359 describes "Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)."

The expert panel noted that 99358 is reported for the first hour of prolonged services on a date other than the date of the face-to-face encounter for all types of evaluation and management services. It may be reported when the prolonged services are performed on a date before or after the face-to-face encounter. It may be reported in conjunction with any level of visit, not just the higher level of visit in a family. 99358 is only reported when at least 30 minutes of time is spent on prolonged services. 99359 is reported in conjunction with 99358 for each additional 30 minutes of prolonged services. It is not reported unless an additional 15 minutes is spent on prolonged services beyond the first 60 minutes (i.e., 75 minutes). All the time for each code is considered intra-service time.

For code 99358, there were 61 respondents of whom 89% found the vignette to be typical. The survey times were 0/50/0/50, the median RVW was 2.45, and the 25th percentile RVW was 1.80.

The current times and RVW for 99358 are: 0/60/0/60/2.10.

The two key reference services were 99205, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter, with times and RVW of 14/59/15/88/3.50, and 99204, Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter, with times and RVW of 10/40/10/60/2.60.

The expert panel agreed that the work of 99358 has not increased since the last survey. In addition, the survey time of 50 minutes is 83% of the current time (60 minutes). This alone supported the survey 25th percentile RVW of 1.80 which is 85% of the current RVW (2.10).

An RVW of 1.80 also places 99358 in proper rank order with 99205 because the intra-service and total times are less, and the intensity is lower. Similarly, while the intra-service time is more than that of 99204, the total is less, as is the intensity. In fact, the WPUT with an RVW of 1.80 is 0.036 which is practically identical to the current WPUT.

Therefore, the expert panel recommends 50 minutes of time, all intra-service, and an RVW of 1.80.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99358

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner How often? Sometimes

Specialty Internal Medicine How often? Sometimes

Specialty Family Medicine How often? Sometimes

Estimate the number of times this service might be provided nationally in a one-year period? 1574289
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. (See attached spreadsheet)

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 211,314 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. (See attached spreadsheet; frequency and percentages are from the 2019 Medicare utilization in the RUC database.)

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99358

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:99359 Tracking Number Original Specialty Recommended RVU: **1.00**
Presented Recommended RVU: **1.00**
Global Period: ZZZ Current Work RVU: **1.00** RUC Recommended RVU: **0.75**

CPT Descriptor: Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
(Use 99359 in conjunction with 99358)
(Do not report 99358, 99359 on the same date of service as 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99483, 993X0, 99417)

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. The physician or other qualified healthcare professional indicated that past medical records are needed from the patient's prior physicians or other qualified healthcare professionals and they are reviewed upon arrival.

Percentage of Survey Respondents who found Vignette to be Typical: 92%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: (not applicable)

Description of Intra-Service Work: Continue or prepare for the work of face-to-face evaluation and management on a date of service different from that of the face-to-face evaluation and management. Spend 15 to 44 minutes beyond the first hour of such evaluation and management in non-face-to-face tasks, such as extensive record review, review of imaging studies, discussions with other physicians and qualified healthcare professionals, and ongoing, disease-specific patient management.

Description of Post-Service Work: (not applicable)

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021
Presenter(s):	Megan Adamson, MD; Elizabeth Blanchard, MD; Audrey Chun, MD; Omar Hussain, DO; Charles Hamori, MD, FACP; Kevin Kerber, MD; Steven Krug, MD; Stephen Lahey, MD; James Levett, MD; Kano Mayer, MD; Phillip E. Rodgers, MD, FAAHPM; Fredrica Smith, MD; Karin Swartz, MD; Korinne Van Keuren, DNP, MS, RN, CPNP-AC, APRN-BC, RNFA
Specialty Society(ies):	American Academy of Family Physicians, American Academy of Hospice and Palliative Medicine, American Academy of Neurology, American Academy of Pediatrics, American Association for Thoracic Surgery, American College of Physicians, American College of Rheumatology, American Geriatrics Society, American Nurses Association, American Society of Clinical Oncology, American Thoracic Society, American College of Chest Physicians, North American Spine Society, Society of Thoracic Surgeons
CPT Code:	99359
Sample Size: 20981	**Resp N:** 54
Description of Sample:	Random

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**2.00**	20.00	1200.00
Survey RVW:	0.50	0.75	**1.12**	2.25	45.00
Pre-Service Evaluation Time:			**0.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	0.00	24.00	**30.00**	30.00	90.00

Immediate Post Service-Time:	**0.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

ZZZ Global Code

CPT Code:	99359	**Recommended Physician Work RVU: 0.75**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**0.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**30.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)
ZZZ Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**0.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99439	ZZZ	0.54	**RUC Time**

CPT Descriptor Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
99458	ZZZ	0.61	**RUC Time**

CPT Descriptor Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (List separately in addition to code for primary procedure)

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
99202	XXX	0.93	**RUC Time**	2,490,658

CPT Descriptor 1 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total

Most Recent

MPC CPT Code 2	Global	Work RVU	Time Source	Medicare Utilization
11042	000	1.01	**RUC Time**	1,938,307

CPT Descriptor 2 Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 25 **% of respondents:** 46.2 **%**

Number of respondents who choose 2nd Key Reference Code: 9 **% of respondents:** 16.6 **%**

TIME ESTIMATES (Median)

	CPT Code: 99359	**Top Key Reference CPT Code:** 99439	**2nd Key Reference CPT Code:** **99458**
Median Pre-Service Time	0.00	0.00	0.00
Median Intra-Service Time	30.00	15.00	20.00
Median Immediate Post-service Time	0.00	0.00	0.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**30.00**	**15.00**	**20.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	12%	40%	36%	12%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	12%	36%	52%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	24%	52%	24%
Physical effort required	28%	52%	20%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	20%	40%	40%

Survey Code Compared to 2nd Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	22%	33%	33%	11%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	11%	67%	22%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	11%	67%	22%
Physical effort required	38%	38%	25%

Psychological Stress	Less	Identical	More
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	22%	33%	44%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Code 99358 describes "Prolonged evaluation and management service before and/or after direct patient care; first hour," and code 99359 describes "Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)."

The expert panel noted that 99358 is reported for the first hour of prolonged services on a date other than the date of the face-to-face encounter for all types of evaluation and management services. It may be reported when the prolonged services are performed on a date before or after the face-to-face encounter. It may be reported in conjunction with any level of visit, not just the higher level of visit in a family. 99358 is only reported when at least 30 minutes of time is spent on prolonged services. 99359 is reported in conjunction with 99358 for each additional 30 minutes of prolonged services. It is not reported unless an additional 15 minutes is spent on prolonged services beyond the first 60 minutes (i.e., 75 minutes). All the time for each code is considered intra-service time.

For code 99359, there were 54 respondents of whom 92% found the vignette to be typical. The survey times were 0/30/0/30, the median RVW was 1.12. and the 25th percentile RVW was 0.75.

The current times and RVW are 0/30/0/30/1.00.

The two key reference services were 99214, Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter, with times and RVW of 7/30/10/47/1.92, and 95939, Central motor evoked potential study (transcranial motor stimulation); in upper and lower limbs, with times and RVW of 15/30/15/60/2.25.

The expert panel agreed that the work of 99359 has not increased since the last survey. They also noted that the survey time is identical to the current time. The expert panel agreed it was important to maintain proper rank order with 99358. They noted that the survey time of 30 minutes is 60% of the survey time for 99358 and that 60% of the recommended 99358 RVW (1.80) is 1.08 which supports maintaining the current RVW of 1.00. This would also place the WPUT for 99359 in proper rank order to 99358 (.033 vs. .036).

The expert panel also reviewed other RUC reviewed ZZZ global codes with 20-40 minutes intra-time, and an RVW between 0.5 and 1.5. Of the 51 codes found, the expert panel agreed that the most appropriate comparator was 99458, Remote Physiologic Monitoring, each additional 20 minutes that can be performed by a qualified health professional or clinical staff, which has times and RVW of 0/20/0/20/0.61. These values support maintaining the current RVW of 1.00 because the time and RVW of 99458 are 67% and 61% that of 99359.

Therefore, the expert panel recommends a time of 30 minutes, all intra-service, and an RVW of 1.00.

(NOTE: After deliberation by the RUC, the specialties subsequently recommended and the RUC approved an RVW of 0.75 with a time of 30 minutes, all intra-service.)

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

- ☒ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
- ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
- ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
- ☐ Multiple codes are used to maintain consistency with similar codes.
- ☐ Historical precedents.
- ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

	Code	Global	Work RVU	Pre-Time	Intra-Time	Post-Time
3.	99358	XXX	1.80	0	50	0
4.	99359	ZZZ	0.75	0	30	0
5.	Total		2.55	0	80	0

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 99359

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Nurse Practitioner How often? Rarely

Specialty Internal Medicine How often? Rarely

Specialty Family Medicine How often? Rarely

Estimate the number of times this service might be provided nationally in a one-year period? 58564
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. (see attached spreadsheet)

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Specialty Frequency Percentage %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 7,861
If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 Medicare claims data

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? No

---

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Evaluation Management

BETOS Sub-classification:

BETOS Sub-classification Level II:
NA

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 99359

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	AS	AT	AU	AV	AW
13		ISSUE:	Prolonged Services - without direct patient contact (99358-59)																										
14		TAB:	14	Revised (corrected typos) 10-08-2021																									
15	Medicare Volume or					RUC Review Year		IWPUT	Work Per Unit Time	RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
16	% Typical	Source	CPT	Global	DESC		Resp			MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
17		1st REF	99205	XXX	Office or other outpatient visit for the evaluation and management of a new	4/1/2019	25	0.048	0.040			3.50			88	14					59			15					
18		2nd REF	99204	XXX	Office or other outpatient visit for the evaluation and management of a new	4/1/2019	12	0.054	0.043			2.60			60	10					40			10					
19		CURRENT	99358	XXX	Prolonged evaluation and management service before and/or after direct patient	1/1/2020		0.035	0.035			2.10			60						60								
20	89%	SVY	99358	XXX	Prolonged evaluation and management service before and/or		61	0.049	0.049	0.50	1.80	2.45	3.50	28.00	50				0	30	50	60	90		0	2	8	50	3500
21	88%	Primary Care P	99358	XXX	KRS 1 = 99205		24	0.048	0.048	1.00	1.25	2.15	3.50	4.00	45				0	30	45	60	90		0	2	8	50	800
22	91%	MEDICAL	99358	XXX	KRS 1 = 99205		35	0.052	0.052	0.50	1.85	2.60	3.50	28.00	50				1	35	50	60	68		0	1	10	48	3500
23	50%	SURGERY	99358	XXX	KRS 1 = 99205		2	0.035	0.035	2.04	2.06	2.07	2.09	2.10	59.5				59	59	60	60	60		0	1	1	2	2
24		REC	99358	XXX	Prolonged evaluation and management service before			0.036	0.036			1.80			50						50								
25																													
26		1st REF	99439	ZZZ	Chronic care management services with the following		25	0.036	0.036			0.54			15						15								
27		2nd REF	99458	ZZZ	Remote physiologic monitoring treatment management		9	0.031	0.031			0.61			20						20								
28		CURRENT	99359	ZZZ	Prolonged evaluation and management service before and/or after direct patient	1/1/2020		0.033	0.033			1.00			30						30								
29	92%	SVY	99359	ZZZ	Prolonged evaluation and management service before		54	0.037	0.037	0.50	0.75	1.12	2.25	45.00	30				0	24	30	30	90		0	0	2	20	1200
30	92%	Primary Care P	99359	ZZZ	KRS 1 = 99439		21	0.033	0.033	0.50	0.60	1.00	2.00	5.00	30				0	25	30	60	90		0	0	2	30	160
31	94%	MEDICAL	99359	ZZZ	KRS 1 = 99439		31	0.046	0.046	0.50	0.75	1.30	2.50	45.00	28				2	20	28	30	90		0	0	3	19	1200
32	50%	SURGERY	99359	ZZZ	KRS 1 = 99458		2	0.034	0.034	1.00	1.01	1.01	1.02	1.02	29.5				29	29	30	30	30		0	0	1	1	1
33		REC	99359	ZZZ	Prolonged evaluation and management service before			0.025	0.025			0.75			30						30								
34																													

Med Specialty Grouping E-M

	A	B	C	D
1	Qualtrics Code	CMS Code	Grouping	CMS Specialty
2	20	08	PCP	Family Practice
3	24	38	PCP	Geriatric Medicine
4	71	17	PCP	Hospice And Palliative Care
5	74	11	PCP	Internal Medicine
6	85	50	PCP	Nurse Practitioner
7	95	37	PCP	Pediatric Medicine
8	98	97	PCP	Physicians Assistant
9				
10	9	78	Surgery	Cardiac Surgery
11	14	28	Surgery	Colorectal Surgery (Proctology)
12	23	02	Surgery	General Surgery
13	26	98	Surgery	Gynecological Oncology
14	27	40	Surgery	Hand Surgery
15	75	C3	Surgery	Interventional Cardiology
16	83	14	Surgery	Neurosurgery
17	86	16	Surgery	Obstetrics/Gynecology
18	87	18	Surgery	Ophthalmology
19	90	20	Surgery	Orthopedic Surgery
20	92	04	Surgery	Otolaryngology
21	99	24	Surgery	Plastic And Reconstructive Surgery
22	108	91	Surgery	Surgical Oncology
23	109	33	Surgery	Thoracic Surgery
24	110	34	Surgery	Urology
25	111	77	Surgery	Vascular Surgery
26	8	21	Medicine	Cardiac Electrophysiology
27	10	06	Medicine	Cardiology
28	19	46	Medicine	Endocrinology
29	21	10	Medicine	Gastroenterology
30	28	82	Medicine	Hematology
31	29	83	Medicine	Hematology/Oncology
32	73	44	Medicine	Infectious Disease
33	79	90	Medicine	Medical Oncology
34	80	39	Medicine	Nephrology
35	81	13	Medicine	Neurology
36	88	41	Medicine	Optometry
37	91	12	Medicine	Osteopathic Manipulative Medicine
38	93	72	Medicine	Pain Management
39	97	25	Medicine	Physical Medicine And Rehabilitation
40	103	29	Medicine	Pulmonary Disease
41	105	66	Medicine	Rheumatology
42	15		Hospital	Hospitalists
43	72		Hospital	Critical Care

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99358, 99359

SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS

PRESENTER(S): Audrey Chun, MD, Phil Rodgers, MD, Omar Hussain, MD, Elizabeth Volpert, DNP, APRN, Steve Krug, MD, Charles, Hamori, MD, Kevin Kerber, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2019
Tab 14
Revised: October 6, 2021

****** No PE inputs are recommended for code 993X0 ******

CPT Code	Long Descriptor	Global Period
+99417	Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management services) (Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483) (Do not report 99417 on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416) (Do not report 99417 for any time unit less than 15 minutes)	ZZZ
+993X0	Prolonged inpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient Evaluation and Management services) (Use 993X0 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310) (Do not report 993X0 on the same date of service as 90833, 90836, 90838, 99358, 99359) (Do not report 993X0 for any time unit less than 15 minutes) (For prolonged psychotherapy services, use 908X0)	ZZZ
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	XXX
+99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service) (Use 99359 in conjunction with 99358) (Do not report 99358, 99359 on the same date of service as 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99242, 99243, 99244, 99245, 99252, 99253, 99254, 99255, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99483, 993X0, 99417)	ZZZ

Vignette(s) (*vignette required even if PE only code(s)*):

CPT Code	Vignette
+99417	Office visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.
+993X0	Hospital visit for a patient with a chronic illness with severe exacerbation that poses a threat to life or bodily function, or an acute illness/injury that poses a threat to life or bodily function.
99358	An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. The physician or other qualified healthcare professional indicated that

	past medical records are needed from the patient's prior physicians or other qualified healthcare professionals and they are reviewed upon arrival.
+99359	An 85-year-old new patient with multiple complicated medical problems has moved to the area to live closer to her daughter. The physician or other qualified healthcare professional indicated that past medical records are needed from the patient's prior physicians or other qualified healthcare professionals and they are reviewed upon arrival.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   A consensus panel consisting of RUC advisors and subject matter experts from the surveying societies met via conference calls to review any data and existing PE inputs to develop the final recommendations presented in the PE worksheet.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   Current codes, plus recent E/M April 2019 survey RUC approved and CMS final recommendations.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see the *Billed Together* tab in the RUC Database)

   Codes 99358 and 99359 are not typically reported on the same day of service as an E/M code. Codes 99417 and 993X0 are add-on codes for certain E/M services, which are identified in parentheticals following the code descriptors.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see the *Billed Together* tab in the RUC Database)

+99417 MEDICARE SPECIALIT (NON-FACILITY ONLY	**+993X0**	**99358** MEDICARE SPECIALITY (NON-FACILITY ONLY)		**99359** MEDICARE SPECIALITY (NON-FACILITY ONLY)	
Detail not available.	Detail not available	NURSE PRACTITIONER	33.3%	NURSE PRACTITIONER	19.0%
		INTERNAL MEDICINE	14.6%	FAMILY MEDICINE	16.9%
		FAMILY MEDICINE	13.4%	INTERNAL MEDICINE	13.1%
		CARDIOLOGY	5.0%	PSYCHIATRY	12.3%
		PHYSICIANS ASSISTANT	4.2%	PHYSICIANS ASSISTANT	9.5%
		NEUROLOGY	4.0%	GENERAL PRACTICE	4.7%
		INTERVENTIONAL PAIN MANAGEMENT	2.3%	NEUROLOGY	4.3%
				GERIATRIC MEDICINE	2.9%
		HEMATOLOGY/ONCOLOGY	1.9%	EMERGENCY MEDICINE	2.1%
		GERIATRIC MEDICINE	1.7%	DERMATOLOGY	1.9%

		PSYCHIATRY	1.7%	ALLERGY/IMMUNOLOGY	1.5%
		GENERAL PRACTICE	1.3%	CARDIOLOGY	1.4%
		ENDOCRINOLOGY	1.3%	GYNECOLOGICAL ONCOLOGY	1.0%
		PAIN MANAGEMENT	1.1%	RHEUMATOLOGY	1.0%
		PHYSICAL MEDICINE AND REHABILITATION	1.1%		
		PULMONARY DISEASE	1.1%		

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

Not applicable.

(NOTE: CMS does not currently recognize code 99417 for payment. The recommended inputs for code 99417 are the same as those that CMS currently includes in G2212 (Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPTcodes 99205, 99215 for office or other outpatient evaluation and management services) (do not report g2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (do not report g2212 for any time unit less than 15 minutes).)

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

N/A

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

N/A

8. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

N/A

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99358, 99359
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS
PRESENTER(S): Audrey Chun, MD, Phil Rodgers, MD, Omar Hussain, MD, Elizabeth Volpert, DNP, APRN, Steve Krug, MD, Charles, Hamori, MD, Kevin Kerber, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

9. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

    b. Service period (includes pre, intra and post):

    c. Post-service period:

Can be a combination of additional time for additional notes in the appropriate charts, and or calls above the E/M.

11. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

N/A

12. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A

13. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):

N/A

14. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99358, 99359
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS
PRESENTER(S): Audrey Chun, MD, Phil Rodgers, MD, Omar Hussain, MD, Elizabeth Volpert, DNP, APRN, Steve Krug, MD, Charles, Hamori, MD, Kevin Kerber, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

N/A

19. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A

22. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

No equipment minutes are recommended for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038.

23. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time)*. If you have selected "other formula" for any of the equipment please explain here:

The use of some space to conduct the prolonged services is necessary. We followed the guidance of the E/M outpatient services below: The specialty societies recommend the "Office Visits" equipment formula for EQ189 otoscope-ophthalmoscope (wall unit) and EF023 table, exam for code 99417.

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 99358, 99359
SPECIALTY SOCIETY(IES): AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS
PRESENTER(S): Audrey Chun, MD, Phil Rodgers, MD, Omar Hussain, MD, Elizabeth Volpert, DNP, APRN, Steve Krug, MD, Charles, Hamori, MD, Kevin Kerber, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)
NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

- All direct practice expense inputs were removed from code 993X0 since it is a facility-only code.
- Equipment ED021, *Computer, desktop, w-monitor,* was removed from the recommended inputs for codes 99417, 99358, and 99359 on the basis that this is an indirect expense.
- Equipment EQ189, *otoscope-ophthalmoscope (wall unit)*, and EF023, *exam table*, were removed from the recommended inputs for 99358 and 99359 since the patient is not present for these services.
- Consistent with the current inputs for G2212 and the RUC's prior recommendations for 99417, equipment EQ189, *otoscope-ophthalmoscope (wall unit)*, and EF023, *exam table*, were included in the recommended inputs for code 99417 in the non-facility setting, since it is an add-on to a face-to-face evaluation and management service in the outpatient (i.e., non-facility) setting and the patient will typically be occupying an exam room during the prolonged service.

	A	B	D	E	F
1	RUC Practice Expense Spreadsheet - Updated September 30, 2021				
2					
3		***RUC Collaboration Website***			
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 14 & 15 Prolonged Services Specialty: AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**
5		**LOCATION**			
6		**GLOBAL PERIOD**			
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**			
8		**TOTAL CLINICAL STAFF TIME**	L037D		
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L037D		
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L037D		
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L037D		
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**			
13		**PRE-SERVICE PERIOD**			
14		**Start: Following visit when decision for surgery/procedure made**			
15	CA001		L037D		
16	CA002		L037D		
17	CA003		L037D		
18	CA004		L037D		
19	CA005		L037D		
20	CA006		L037D		
21	CA007		L037D		
22	CA008		L037D		
23	CA048		L037D		
26		*Other activity: please include short clinical description here and type*	L037D		
29		**End: When patient enters office/facility for surgery/procedure**			
30		**SERVICE PERIOD**			
31		**Start: When patient enters office/facility for surgery/procedure:**			
32		**Pre-Service (of service period)**			
33	CA009		L037D		
34	CA010		L037D		
37	CA013		L037D		
40	CA016		L037D		
42	CA049		L037D		
45	CA050		L037D		
48		**Intra-service (of service period)**			
51	CA020		L037D		
56		*Other activity: please include short clinical description here and type*	L037D		
59		**Post-Service (of service period)**			
62	CA024		L037D		
75	CA051		L037D		
78	CA052		L037D		
81		**End: Patient leaves office/facility**			
82		**POST-SERVICE PERIOD**			
83		**Start: Patient leaves office/facility**			
84	CA037		L037D		
85	CA038		L037D		
92	CA039		L037D		
99		**End: with last office visit before end of global period**			

	A	B	D	E	F
1	RUC Practice Expense Spreadsheet - Updated September 30, 2021				
2					
3		*RUC Collaboration Website*			
4	Clinical Activity Code	Meeting Date: October 2021 Revision Date (if applicable): Tab: 14 & 15 Prolonged Services Specialty: AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS	Clinical Staff Type Code	Clinical Staff Type	Clinical Staff Type Rate Per Minute
5		LOCATION			
6		GLOBAL PERIOD			
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME			
8		TOTAL CLINICAL STAFF TIME	L037D		
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	L037D		
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	L037D		
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	L037D		
100	Supply Code	MEDICAL SUPPLIES	PRICE	UNIT	
101		TOTAL COST OF SUPPLY QUANTITY x PRICE			
102	SA047				
103	SM022				
110	Equipment Code	EQUIPMENT	Purchase Price	Equipment Formula	Cost Per Minute
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE			
112	EQ189			Office Visits	
113	EF023			Office Visits	
114	ED021			Other Formula	
115	EF048			Other Formula	

	A	B	G	H	I	J	K	L	M	N
1	RUC Practice Expense Spreadsheet - Updated September 30, 2021		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2			99358		99358		99359		99359	
3		*RUC Collaboration Website*	Prolonged evaluation and management service before and/or after direct patient care; first hour		Prolonged evaluation and management service before and/or after direct patient care; first hour		Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List		Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List	
4	Clinical Activity Code	Meeting Date: October 2021 Revision Date (if applicable): Tab: 14 & 15 Prolonged Services Specialty: AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS								
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX	XXX	XXX	XXX	ZZZ	ZZZ	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		TOTAL CLINICAL STAFF TIME	3.0	0.0	3.0	0.0	3.0	0.0	3.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	0.0	3.0	0.0	3.0	0.0	3.0	0.0
12		TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13		PRE-SERVICE PERIOD								
14		Start: Following visit when decision for surgery/procedure made								
15	CA001									
16	CA002									
17	CA003									
18	CA004									
19	CA005									
20	CA006									
21	CA007									
22	CA008									
23	CA048									
26		*Other activity: please include short clinical description here and type*								
29		End: When patient enters office/facility for surgery/procedure								
30		SERVICE PERIOD								
31		Start: When patient enters office/facility for surgery/procedure:								
32		Pre-Service (of service period)								
33	CA009									
34	CA010									
37	CA013									
40	CA016									
42	CA049									
45	CA050									
48		Intra-service (of service period)								
51	CA020									
56		*Other activity: please include short clinical description here and type*								
59		Post-Service (of service period)								
62	CA024									
75	CA051									
78	CA052									
81		End: Patient leaves office/facility								
82		POST-SERVICE PERIOD								
83		Start: Patient leaves office/facility								
84	CA037		3		3		3		3	
85	CA038									
92	CA039		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
99		End: with last office visit before end of global period								

	A	B	G	H	I	J	K	L	M	N
1	RUC Practice Expense Spreadsheet - Updated September 30, 2021		CURRENT		RECOMMENDED		CURRENT		RECOMMENDED	
2			99358		99358		99359		99359	
3		*RUC Collaboration Website*	Prolonged evaluation and management service before and/or after direct patient care; first hour		Prolonged evaluation and management service before and/or after direct patient care; first hour		Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List		Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List	
4	Clinical Activity Code	Meeting Date: October 2021 Revision Date (if applicable): Tab: 14 & 15 Prolonged Services Specialty: AAFP, AAHPM, AAN, AAP, AATS, ACP, ACRh, AGS, ANA, ASCO, ATS, CHEST, NASS, STS								
5		LOCATION	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility	Non Fac	Facility
6		GLOBAL PERIOD	XXX	XXX	XXX	XXX	ZZZ	ZZZ	ZZZ	ZZZ
7		TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
8		TOTAL CLINICAL STAFF TIME	3.0	0.0	3.0	0.0	3.0	0.0	3.0	0.0
9		TOTAL PRE-SERVICE CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
10		TOTAL SERVICE PERIOD CLINICAL STAFF TIME	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
11		TOTAL POST-SERVICE CLINICAL STAFF TIME	3.0	0.0	3.0	0.0	3.0	0.0	3.0	0.0
100	Supply Code	MEDICAL SUPPLIES								
101		TOTAL COST OF SUPPLY QUANTITY x PRICE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
102	SA047									
103	SM022									
110	Equipment Code	EQUIPMENT								
111		TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
112	EQ189		0		0		0		0	
113	EF023		0		0		0		0	
114	ED021		0		0		0		0	
115	EF048									

AMA/Specialty Society RVS Update Committee Summary of Recommendations
Screen: CMS Request – Final Rule for 2020

October 2021

Prolonged Services – on the Date of an E/M – Tab 15

In February 2021, the CPT Editorial Panel deleted Prolonged Service with Direct Patient Contact (Except with Office or Other Outpatient Services) subsection including codes 99354-99357, revised CPT code 99417 and created a new prolonged inpatient service code 993X0. In October 2021, the specialty societies surveyed the two prolonged service on the date of an E/M codes (99417, 993X0) but did not obtain the required number of survey responses for code 993X0. The specialty noted, and the RUC concurred, that the January 2022 meeting is still within the current cycle and would not delay recommendations pertinent to the 2023 Medicare Physician Payment Schedule.

The RUC recommends that the prolonged services on the date of an E/M codes be postponed until January 2022 so the specialty societies can obtain the required number of survey responses for CPT codes 99417 and 993X0.

CPT Code	Tracking Number	CPT Descriptor	Global Period	Work RVU Recommendation
Evaluation and Management **Prolonged Services** ~~**Prolonged Service With Direct Patient Contact (Except with Office or Other Outpatient Services)**~~ ~~Codes 99354-99357 are used when a physician or other qualified health care professional provides prolonged service(s) involving direct patient contact that is provided beyond the usual service in either the inpatient, observation or outpatient setting, except with office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Direct patient contact is face-to-face and includes additional non-face-to-face services on the patient's floor or unit in the hospital or nursing facility during the same session. This service is reported in addition to the primary procedure. Appropriate codes should be selected for supplies provided or other procedures performed in the care of the patient during this period.~~ ~~Codes 99354-99355 are used to report the total duration of face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service in the outpatient setting, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Codes 99356-99357 are used to report the total duration of time spent by a physician or other qualified health care professional at the bedside and on the patient's floor or unit in the hospital or nursing facility on a given date providing prolonged service to a patient, even if the time spent by the physician or other qualified health care professional on that date is not continuous.~~ ~~Time spent performing separately reported services other than the E/M or psychotherapy service is not counted toward the prolonged services time.~~				

~~Code 99354 or 99356 is used to report the first hour of prolonged service on a given date, depending on the place of service.~~

~~Either code should be used only once per date, even if the time spent by the physician or other qualified health care professional is not continuous on that date. Prolonged service of less than 30 minutes total duration on a given date is not separately reported.~~

~~Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour, depending on the place of service. Either code may also be used to report the final 15-30 minutes of prolonged service on a given date. Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.~~

~~The use of the time based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook.~~

~~For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional, use 99415, 99416. Do not report 99354, 99355 with 99415, 99416, 99417.~~

~~For prolonged total time in addition to office or other outpatient services (ie, 99205, 99215), use 99417.~~

~~The following table illustrates the correct reporting of prolonged physician or other qualified health care professional service with direct patient contact in the inpatient or observation setting beyond the usual service time.~~

~~**Total Duration of Prolonged Services**~~	~~**Code(s)**~~
~~less than 30 minutes~~	~~Not reported separately~~
~~30-74 minutes (30 minutes - 1 hr. 14 min.)~~	~~99356 X 1~~
~~75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)~~	~~99356 X 1 AND 99357 X 1~~
~~105 or more (1 hr. 45 min. or more)~~	~~99356 X 1 AND 99357 X 2 or more for each additional 30 minutes.~~

~~+ 99354~~	-	~~Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or~~	~~ZZZ~~	~~N/A~~

		~~other outpatient **Evaluation and Management** or psychotherapy service)~~ ~~(Use 99354 in conjunction with 90837, 90847, 99241-99245, 99324-99337, 99341-99350, 99483)~~ ~~(Do not report 99354 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99415, 99416, 99417)~~		
~~+99355~~	-	~~each additional 30 minutes (List separately in addition to code for prolonged service)~~ ~~(Use 99355 in conjunction with 99354)~~ ~~(Do not report 99355 in conjunction with 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99415, 99416, 99417)~~	~~ZZZ~~	~~N/A~~
~~+99356~~	-	~~Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient **Evaluation and Management** service)~~ ~~(Use 99356 in conjunction with 90837, 90847, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310)~~	~~ZZZ~~	~~N/A~~
~~+99357~~	-	~~each additional 30 minutes (List separately in addition to code for prolonged service)~~ ~~(Use 99357 in conjunction with 99356)~~ (99354, 99355 have been deleted. For prolonged evaluation and management services on the date of an office or other outpatient service, home and residence service, or cognitive assessment and care plan, use 99417. For prolonged psychotherapy, use 908X0) (99356, 99357 have been deleted. For prolonged service on the date of an inpatient or observation or nursing facility service, use 993X0. For prolonged psychotherapy, use 908X0)	~~ZZZ~~	~~N/A~~

Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management ~~Office or Other Outpatient~~ Service

Code 99417 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of office or other outpatient services, office consultation or other outpatient evaluation and management service (ie, 99205, 99215, 99245, 99345, 99350, 99483). Code 993X0 is used to report prolonged total time (ie, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of an inpatient service (ie, 99223, 99233, 99236, 99255, 99306, 99310). Prolonged total time is time that is 15 minutes beyond the time required to report the highest-level primary service. Codes 99417 and 993X0 ~~is~~ are only used when the primary ~~office or other outpatient~~ service has been selected using time alone as the basis and only after the ~~minimum~~ time required to report the highest-level service ~~(ie, 99205 or 99215)~~ has been exceeded by 15 minutes. To report a unit of 99417 or 993X0, 15 minutes of ~~additional~~ time must have been attained. Do not report 99417 or 993X0 for any ~~additional~~ time increment of less than 15 minutes.

~~The listed time ranges for 99205 (ie, 60-74 minutes) and 99215 (ie, 40-54 minutes) represent the complete range of time for which each code may be reported. Therefore,~~ When reporting 99417 or 993X0, the initial time unit of 15 minutes should be added once the ~~minimum~~ time in the primary E/M code has been surpassed by 15 minutes. For example, to report the initial unit of 99417 for a new patient encounter (99205), do not report 99417 until at least 15 minutes of time has been accumulated beyond 60 minutes (ie, 75 minutes) on the date of the encounter. For an established patient encounter (99215), do not report 99417 until at least 15 minutes of time has been accumulated beyond 40 minutes (ie, 55 minutes) on the date of the encounter.

Time spent performing separately reported services other than the primary E/M service and prolonged E/M service is not counted toward the primary E/M and ~~time to report 99205, 99215 and~~ prolonged services time.

For prolonged services on a date other than the date of a face-to-face evaluation and management encounter, ~~including office or other outpatient services (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215),~~ see 99358, 99359. For E/M services that require prolonged clinical staff time and may include face-to-face services by the physician or other qualified health care professional ~~QHP~~, see 99415, 99416. Do not report 99417 or 993X0 in conjunction with ~~99354, 99355,~~ 99358, 99359, 99415, 99416.

~~Prolonged services of less than 15 minutes total time is not reported. on the date of office or other outpatient service when the highest level is reached (ie, 99205, 99215).~~

✚▲99417	K5	Prolonged ~~office or other~~ outpatient evaluation and management service(s) time with or without direct patient contact beyond the ~~minimum~~ required time ~~with or without direct patient contact beyond the usual service~~ of the primary service ~~procedure encounter which~~ when the primary service level has been selected using total time, ~~requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service,~~ each 15 minutes of total time (List separately in addition to ~~codes 99205, 99215 for office or other~~ the code of the outpatient Evaluation and Management services) (Use 99417 in conjunction with 99205, 99215, 99245, 99345, 99350, 99483) (Do not report 99417 on the same date of service as ~~99354, 99355,~~ 90833, 90836, 90838, 99358, 99359, 99415, 99416)	ZZZ	Postpone until January 2022 (2021 work RVU = 0.00)

<table>
<tr><td></td><td></td><td>(Do not report 99417 for any time unit less than 15 minutes)
<u>(For prolonged psychotherapy services, use 908X0)</u></td><td></td><td></td></tr>
<tr><td>+●993X0</td><td>K6</td><td>Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management services)
(Use 993X0 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310)
(Do not report 993X0 on the same date of service as 90833, 90836, 90838, 99358, 99359)
(Do not report 993X0 for any time unit less than 15 minutes)
(For prolonged psychotherapy services, use 908X0)
<table>
<tr><th>Total Duration of New Patient Office or Other Outpatient Services (use with 99205)</th><th>Code(s)</th></tr>
<tr><td>less than 75 minutes</td><td>Not reported separately</td></tr>
<tr><td>75-89 minutes</td><td>99205 X 1 AND 99417 X 1</td></tr>
<tr><td>90-104 minutes</td><td>99205 X 1 AND 99417 X 2</td></tr>
<tr><td>105 minutes or more</td><td>99205 X 1 AND 99417 X 3 or more for each additional 15 minutes</td></tr>
<tr><th>Total Duration of Office or Other Outpatient Consultation Services (use with 99245)</th><th>Code(s)</th></tr>
</table></td><td>ZZZ</td><td>Postpone until January 2022</td></tr>
</table>

		<u>less than XX + 15 minutes</u>	Not reported separately			
		<u>XX+15 to XX+29 minutes</u>	99245 X 1 AND 99417 X ~~2~~1			
		<u>XX+30 to XX+44</u>	<u>99245 X 1 and 99417 X 2</u>			
		<u>XX+45 minutes or more</u>	<u>99245 X 1 AND 99417 X 3 or more for each additional 15 minutes</u>			
G2212		Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to cpt codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report g2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (do not report g2212 for any time unit less than 15 minutes)			XXX	**Recommend for Deletion** (2021 work RVU = 0.61)

~~Comparison of Prolonged Services Codes 99354, 99355, 99356, 99357, 99358, 99359, 99417 Table~~

Code	Patient Contact	Minimum Reportable Prolonged Services Time (Single Date of Service)	Use In Conjunction With	*Do Not Report With	Other Prolonged Service(s) Reportable On Same Date Of Service
+99354	Face-to-Face Only	30 minutes (Beyond listed typical time)	90837, 90847, 99241-99245, 99324-99337, 99341-99350, 99483	99202-99215, 99415, 99416, 99417	99358, 99359
+99355	Face-to-Face Only	Each additional 15 minutes (Beyond 99354)	99354	99202-99215, 99415, 99416, 99417	99358, 99359
+99356	Face-to-Face and Unit/ Floor Time	30 minutes (Beyond listed typical time)	90837, 90847, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310		99358, 99359
+99357	Face-to-Face and Unit/ Floor Time	Each additional 15 minutes (Beyond 99356)	99356		99358, 99359
99358	Non-Face-to-Face Only	30 minutes	Must relate to a service where face-to-face care has or will occur. This is not an add-on code and is not used in conjunction with a base code.	99202-99215, 99417 On same date of service	99354, 99356
+99359	Non-Face-to-Face Only	Each additional 15 minutes (Beyond 99358)	99358	99202-99215, 99417 On same date of service	99354, 99356

+99417	Both	Reported with 99205: 75 minutes or more Reported with 99215: 55 minutes or more ***(Total time on the date of encounter)***	99205, 99215	99354, 99355, 99358, 99359, 99415, 99416	N/A
*Do not count the time of any separately reported service as Prolonged Services time 99355 is for prolonged services time beyond 99354 and may be reported in multiple units 99357 is for prolonged services time beyond 99356 and may be reported in multiple units 99359 is for prolonged services time beyond 99358 and may be reported in multiple units 99417 is for prolonged services time beyond 99205 or 99215 and may be reported in multiple units of at least 15 minutes					

September 30, 2021

Ezequiel Silva III, MD
Chair, Relative Value Scale Update Committee (RUC)
American Medical Association
330 North Wabash, Office 45-372
Chicago, IL 60611

RE: Prolonged Services – on the Date of an E/M (99417, 993X0) (Tab 15)

Dear Dr. Silva:

The specialty societies listed below submitted a Level of Interest of "1" for the codes for prolonged services on the date of an evaluation and management service (i.e., codes 99417 and 993X0), which represent Tab 15 on the upcoming RUC agenda. Based on anticipated Medicare utilization, a valid RUC survey requires at least 75 respondents for each of these codes.

We have kept the survey for these two codes open as long as possible to get as many responses as possible. However, we did not reach our required minimum for code 993X0 in time to send summary data to the RUC by the deadline for handouts for the meeting. Despite our best efforts, which included RUC-approved reminders to surveyees, (as well as adding more potential surveyees), we have been unable to obtain the required number of responses for code 993X0. To date, we have 84 responses for code 99417 and 59 responses for 993X0.

Accordingly, the specialty societies involved in this survey are writing to request more time so we can reach the required number of responses for 993X0 and present valid results for both codes to the RUC. Specifically, we request a deferral of Tab 15 to the January 2022 RUC meeting, by which time we expect to have the necessary number of responses. We note that the January 2022 meeting is still within the current cycle and won't delay recommendations pertinent to the 2023 Medicare physician fee schedule.

Thank you for your time and consideration. We look forward to successfully completing these surveys and presenting to the RUC in January.

Sincerely,

American Academy of Family Physicians
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Pediatrics
American Association of Thoracic Surgery
American College of Chest Physicians
American College of Physicians
American College of Rheumatology
American Geriatrics Society
American Nurses Association
American Society of Clinical Oncology
American Thoracic Society
North American Spine Society
Society of Thoracic Surgeons

AMA/Specialty Society RVS Update Committee Summary of Recommendations
High Volume Growth

October 2021

Contrast X-Ray of Knee Joint – Tab 16

CPT code 73580 was first identified via the high-volume growth screen in 2008. The long history of this code is detailed in the Summary of Recommendation (SOR) form. Most recently, the specialty societies noted that the increased growth in volume was due to miscoding of the related CPT code 27370 *Injection of contrast for knee arthrography*. To address this miscoding, CPT code 27370 was deleted and replaced with the new CPT code 27369 *Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography* which was valued by the RUC in October 2017. In 2019, CPT code 27370 was deleted and a *CPT Assistant* article for CPT code 27369 was published in August 2019. Utilization of CPT code 73580 subsequently decreased in 2019 concurrent with the deletion of 27370 and clarification of the appropriate use of these codes.

CPT code 73580 describes the work involved with radiologic supervision and interpretation of x-ray images obtained during arthrography of the knee, as well as fluoroscopic guidance for the arthrogram procedure. The RUC noted that there is a separate CPT code 77002 *Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)* which describes fluoroscopic guidance for an arthrogram performed with CT or MR. However, surveyed code 73580 includes the work of fluoroscopic guidance. The injection for the arthrogram procedure is reported separately for x-ray, CT, and MR arthrography. The RUC noted that CPT code 73580 is typically (91.6%) reported with CPT code 27369 and was careful to avoid duplication of either physician work and/or practice expense inputs in the recommendation for 73580. In October 2020, the RAW had recommended that CPT code 73580 be referred to CPT to be bundled with CPT code 27369. In February 2021, the specialty society notified AMA staff that they would not be taking these services to CPT to bundle. They noted that the RUC rationale for CPT code 27369 provides additional information, including why these services were not previously bundled. Specifically, CPT found that bundling the injection code into the arthrography base procedure would not be ideal because it would involve edits to over 70 CPT codes.

In March 2021, the Relativity Assessment Workgroup (RAW) noted that code 73580 was never surveyed and remains CMS/Other sourced, while the specialty societies indicated that they would like to see if utilization decreases further when additional data are available. The RAW recommended, and the RUC agreed, that CPT code 73580 be surveyed for the October 2021 RUC meeting and that the effectiveness of the *CPT Assistant* article should be reexamined in two years (October 2023).

In March 2021, the RAW also noted that although CPT code 73580 describes *Radiologic examination, knee, arthrography, radiological supervision and interpretation*, based on Medicare claims data, it is reported by Diagnostic Radiology only 2.3% of the time. The primary providers are Rheumatology, Family Medicine, Orthopedic Surgery and Physical Medicine and Rehabilitation. Prior to the October 2021 RUC meeting, a letter was submitted on behalf of the family medicine, orthopaedic surgeons, physiatry and rheumatology regarding this code. The letter states that that these specialties did not submit interest in surveying, despite being the primary providers of the service per Medicare claims data, as they believe the reporting of this code associated with their specialties is likely due to misreporting and that radiology is the most appropriate

specialty to survey this service. CPT code 73580 was identified to be surveyed for the October 2021 RUC meeting, and radiology elected to survey.

Compelling Evidence
The RUC reviewed and agreed that there is compelling evidence to support a change in physician work for CPT code 73580 based on evidence that: (1) incorrect assumptions were made in the previous valuation and (2) physician work has increased due to changes in technique, knowledge/technology, and the patient population. The RUC noted that CPT code 73580 has never been surveyed and is the result of CMS/Other inputs, thus the methodology for valuation is unknown. Further, the CMS/Other time source is inappropriate to compare the current physician time and work to the survey results.

There has been a change in physician work for CPT code 73580 since CMS assigned a value and times based on the patient population and technology in 1995. In 1995, the typical patient underwent an x-ray arthrogram as an initial diagnostic exam following physician exam and knee radiographs. Today, the patient population has changed. CT and MR arthrography is significantly more common and has largely replaced x-ray arthrography for most patients. X-ray arthrography is reserved for more complex patients who have indwelling hardware from prior surgery that would result in artifact on MR or CT. Whereas it used to be commonly performed, code 73580 now represents a rare procedure that is primarily performed for exceptional patients who cannot receive CT or MR arthrography. Fluoroscopic equipment has also advanced in the past 25 years, allowing for analysis of finer detail and more subtle pathology in these patients. **The RUC concurred that there is compelling evidence that the physician work for this service has changed due to flawed methodology in the CMS valuation and a change in the patient population.**

73580 ***Radiologic examination, knee, arthrography, radiological supervision and interpretation***
The RUC reviewed the survey results from 41 radiologists and determined that the survey 25th percentile work RVU of 0.59 appropriately accounts for the physician work involved in this service. The RUC recommends 5 minutes of pre-service time, 14 minutes of intra-service time and 5 minutes of post-service time as supported by the survey.

The RUC compared CPT code 73580 to the top key reference code 72265 *Myelography, lumbosacral, radiological supervision and interpretation* (work RVU = 0.83- and 15-minutes intra-service time) which is a clinically similar radiological supervision and interpretation service that compares favorably to the survey code times. The key reference service has nearly identical times, but is more intense, as it involves assessment of the central nervous system as compared to the knee joint. Similarly, survey respondents reported that the surveyed code was "somewhat less" intense overall than the key reference code. The surveyed code has one minute less intra-service time and is less intense and complex than the reference code and is therefore appropriately valued lower. The RUC also compared 73580 to the second highest key reference code 74022 *Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest* (work RVU = 0.32- and 5-minutes intra-service time) and noted that the surveyed code requires more intra-service and total time than the reference code and therefore is appropriately valued higher.

For additional support, the RUC compared CPT code 73580 to MPC codes 76519 *Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation* (work RVU = 0.54 and 10 minutes intra-service time) and 74220 *Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study* (work RVU = 0.60 and 10 minutes intra-service time) and noted that the multi-specialty points of comparison services have less intra-service and total time yet the amount of

physician work closely brackets the surveyed code. The RUC concluded that CPT code 73580 should be valued at the 25th percentile work RVU as supported by the survey. **The RUC recommends a work RVU of 0.59 for CPT code 73580.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made no modifications. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
73580	Radiologic examination, knee, arthrography, radiological supervision and interpretation	XXX	0.59

September 8, 2021

Ezequiel Silva, MD
Chair, AMA RUC
AMA Plaza
330 N. Wabash Ave
Chicago, IL 60511

Dear Dr. Silva,

On behalf of the American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American Academy of Physical Medicine & Rehabilitation, and American College of Rheumatology, we are reaching out regarding CPT code 73580 *Radiological examination, knee, arthrography, radiological supervision and interpretation*. This code was identified to be surveyed for the October 2021 RUC meeting, and the American College of Radiology elected to survey. The above listed specialties did not submit interest in surveying, despite being the primary providers of the service per Medicare claims data in the RUC database. Our societies agree the bulk of, if not all, the billing of this code associated with our specialties is likely due to miscoding. We believe radiology is the most appropriate specialty to survey this code since radiologists are most likely to be the specialists billing this service appropriately.

As described in the background provided on the Level of Interest form for this code, we believe the previous increase in billing of code 73580 by our specialties was due to miscoding of the related CPT code 27370 *Injection of contrast for knee arthrography*. To address this issue, CPT code 27370 was deleted and replaced by a new CPT code, 27369 *Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography*. Additionally, a *CPT Assistant* article was published in August 2019 describing these changes and the correct use of codes 73580 and 27369. CPT code 73580 utilization decreased in 2019 concurrent with the deletion of 27370 and clarification of the appropriate use of these codes. Claims went from a high of 49,095 in 2018 down to 30,453, which is the lowest volume for this code since 2012. The societies believe the steps taken in recent years will result in a continued decline in inappropriate use of 73580 by our specialties as more physicians become familiar with the revised coding and instructions and integrate it into their practices.

However, we recognize additional approaches may be needed and the societies have each reviewed the billing associated with their specialties. Based on billing patterns, the societies have agreed that different educational strategies are appropriate.

For instance, in the case of the American College of Rheumatology, the 2018 billing of this code is associated with a single rheumatologist. As it is a single-physician issue, the American College of Rheumatology will be sending communication directly to that member alerting them to the appropriate usage of this code. For the other three societies, billing of 73580 is associated with more than one physician. The three societies intend to provide member education in 2021 via their respective online and/or print newsletter publications to encourage correct coding of 73580. We believe that action in combination with the 2019 coding changes and *CPT Assistant* article should sufficiently address any miscoding.

The societies appreciate your consideration of this letter.

Sincerely,

Megan Adamson, MD
RUC Advisor, American Academy of Family Physicians

William Creevy, MD
RUC Advisor, American Academy of Orthopaedic Surgeons

Carlo Milani, MD
RUC Advisor, American Academy of Physical Medicine & Rehabilitation

Fredrica Smith, MD
RUC Advisor, American College of Rheumatology

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:73580 Tracking Number Original Specialty Recommended RVU: **0.59**
Presented Recommended RVU: **0.59**
Global Period: XXX Current Work RVU: **0.54** RUC Recommended RVU: **0.59**

CPT Descriptor: Radiologic examination, knee, arthrography, radiological supervision and interpretation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 55-year-old female with osteoarthritis of the knee is referred for radiologic examination following contrast injection into the joint (injection coded separately). Images from the procedure are interpreted.

Percentage of Survey Respondents who found Vignette to be Typical: 83%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review the reason for the examination, any pertinent clinical history, and prior imaging studies to become familiar with the patient's anatomy. Confirm that an arthrogram examination is appropriate and plan for the procedure including assessing potential contraindications. Dress in protective radiation attire. Ensure that the fluoroscopic equipment is prepared with proper settings.

Description of Intra-Service Work: The physician provides fluoroscopic guidance for the contrast injection. After contrast has been injected into the joint (reported separately), the physician obtains or supervises the acquisition of the images necessary for evaluation of the bones, joint, and surrounding structures. The physician reviews images for adequate positioning, contrast opacification of the joint space, and pathology. Additional images are obtained, as needed. All images are interpreted (typically 4 radiographs, in addition to any stored fluoroscopic images).

Description of Post-Service Work: Review, edit, and sign the report for the medical record. Communicate results to the referring physician and the patient, when appropriate. Record radiation dose for quality reporting.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021		
Presenter(s):	Lauren Golding, MD; Andy Moriarity, MD		
Specialty Society(ies):	ACR		
CPT Code:	73580		
Sample Size:	1500	**Resp N:**	41
Description of Sample:	The ACR surveyed a total of 1500 members (a random sample of 750 members and a separate random sample of 750 members who perform musculoskeletal and interventional radiology procedures).		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	0.00	0.00	**3.00**	10.00	100.00
Survey RVW:	0.22	0.59	**0.79**	0.83	1.20
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	3.00	8.00	**14.00**	16.00	45.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	73580	**Recommended Physician Work RVU: 0.59**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**14.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	Specialty Recommended Post Time Package	Adjustments/Recommended Post-Service Time
Immediate Post Service-Time:	**5.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
72265	XXX	0.83	**RUC Time**

CPT Descriptor Myelography, lumbosacral, radiological supervision and interpretation

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
74022	XXX	0.32	**RUC Time**

CPT Descriptor Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
76519	XXX	0.54	**RUC Time**	187,253

CPT Descriptor 1 Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74220	XXX	0.60	**RUC Time**	196,573

CPT Descriptor 2 Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study

Other Reference CPT Code	Global	Work RVU	Time Source
76830	XXX	0.69	**RUC Time**

CPT Descriptor Ultrasound, transvaginal

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 26 **% of respondents:** 63.4 **%**

Number of respondents who choose 2nd Key Reference Code: 4 **% of respondents:** 9.7 **%**

TIME ESTIMATES (Median)

	CPT Code: 73580	Top Key Reference CPT Code: 72265	2nd Key Reference CPT Code: **74022**
Median Pre-Service Time	5.00	5.00	1.00
Median Intra-Service Time	14.00	15.00	5.00
Median Immediate Post-service Time	5.00	5.00	1.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**24.00**	**25.00**	**7.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	4%	50%	38%	8%	0%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	50%	46%	4%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	35%	62%	4%

Physical effort required	8%	88%	4%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	69%	27%	4%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	0%	50%	50%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	25%	25%	50%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	0%	50%	50%
Physical effort required	0%	75%	25%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	50%	0%	50%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

- In 2008, CPT code 73580 *(Radiologic examination, knee, arthrography, radiological supervision and interpretation)* was identified via the high-volume growth screen. The specialty commented the increase

in utilization is due to a non-coverage decision for arthroscopic lavage. Physicians were using this code to report different procedures.

- In February 2009, these procedures were referred to CPT for possible deletion of 73580 and 27370 *(Injection of contrast for knee arthrography)* and creation of a new code accurately describing the procedure that is being performed, including the radiologic guidance in the procedure codes.
- In October 2009, the RUC recommended that the specialty society develop a CPT Assistant article to address misreporting of arthrography codes. An article was published in June 2012.
- In April 2015, the RAW reviewed the services, and the RUC recommended that a CPT Assistant article be developed. The Workgroup requested that the specialty societies develop an action plan to address the increase in utilization and effectiveness of a CPT Assistant article.
- In October 2015, the RAW recommended to review this issue in 2017 to determine if the 2015 CPT Assistant article was effective. At that time, the specialty societies noted that the increased utilization was due to persistent miscoding of CPT code 27370. To address this miscoding, CPT code 27370 was deleted and replaced with a new CPT code, 27369 *(Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography)*. The new CPT code was valued by the RUC in October 2017.
- CPT code 27370 was deleted in 2019 (replaced by 27369) and a CPT Assistant article was published in August 2019. CPT code 73580 utilization had decreased in 2019 by roughly 39%, concurrent with the deletion of 27370 and clarification of the appropriate use of these codes.
- In October 2020, the Workgroup recommended that CPT code 73580 be referred to CPT to be bundled with CPT code 27369.
- In February 2021, the specialty society notified AMA staff that they will not be taking these services to CPT to bundle. They noted that the RUC rationale for CPT code 27369 provides additional information, including why these services were not previously bundled. Specifically, CPT found that bundling the injection code into the arthrography base procedure would not be ideal because it would involve edits to over 70 CPT codes.
- In April 2021, the RAW recommended that CPT code 73580 be surveyed and that the effectiveness of the CPT Assistant article for CPT code 27369 should be reexamined in two years (October 2023).

The surveyed code, 73580, describes the work involved with radiologic supervision and interpretation of x-ray images obtained during arthrography of the knee, as well as fluoroscopic guidance for the arthrogram procedure. It is important to note that there is a separate CPT code, 77002 *(Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)),* which describes fluoroscopic guidance for an arthrogram performed with CT or MR. However, survey code 73580 includes the work of fluoroscopic guidance. The injection for the arthrogram procedure is billed separately for x-ray, CT, and MR arthrography.

Survey Process

The ACR surveyed a total of 1500 members (a random sample of 750 members and a separate random sample of 750 members who indicated that they perform musculoskeletal and interventional radiology procedures).

Compelling Evidence

We believe that there is compelling evidence to consider an increase in the value for CPT code 73580 based on evidence that: (1) incorrect assumptions were made in the previous valuation and (2) physician work has increased due to changes in technique, knowledge/technology, and patient population.

(1) **Flawed methodology.** CPT code 73580 has never been surveyed and is the result of CMS/Other inputs.

(2) **Changes in physician work.** We believe that there has been a change in physician work

for CPT code 73580 since CMS assigned a value and time based on the patient population and technology in 1995. In 1995, the typical patient underwent an x-ray arthrogram as an initial diagnostic exam following physician exam and knee radiographs. Today, the patient population has changed. CT and MR arthrography is significantly more common and has largely replaced x-ray arthrography for the vast majority of patients. X-ray arthrography is reserved for more complex patients who have indwelling hardware from prior surgery that would result in artifact on MR or CT. Fluoroscopic equipment has advanced in the past 25 years, allowing for analysis of finer detail and more subtle pathology in these patients.

Work RVU and Time Recommendations

The expert panel recommends the survey 25th percentile value at 0.59 work RVU and survey median times of 5 minutes pre-service, 14 minutes intra-service, and 5 minutes post-service.

Key Reference Services

Our recommended work RVU of 0.59 compares favorably to the most commonly chosen key reference service, CPT code 72265 *(Myelography, lumbosacral, radiological supervision and interpretation),* which is a clinically similar RS&I code. CPT code 72265 has nearly identical survey times of 5 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service time, but is more intense as it involves assessment of the central nervous system as compared to the knee joint. This increased complexity is reflected in the higher work RVU of 0.83 for key reference code 72265 compared to the recommended 0.59 work RVU for the surveyed code. Similarly, survey respondents reported that the surveyed code was "somewhat less" intense overall than key reference code 72265.

The second key reference service code, CPT code 74022 *(Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest)* was chosen by 9.7% of respondents. This code supports the recommendation as well, noting that there are not many RS&I codes from which to choose. Survey times (5 minutes pre-service, 14 minutes intra-service, and 5 minutes post-service time) are higher for the surveyed code, 73580, than those for second key reference code, 74022 (1 minute pre-service, 5 minutes intra-service, and 1 minute post-service time). Additionally, the recommended 0.59 work RVU is appropriately higher than that of key reference code 74022 at 0.32 work RVU. Survey respondents reported that the overall intensity of the surveyed code is identical (50%) or somewhat more (50%) than that of 74022, which in combination with the increased times, supports the recommended work RVU for CPT code 73580.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
74022	Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest	0.32	1	5	1	7	0.055	0.046
73580	**Radiologic examination, knee, arthrography, radiological supervision and interpretation**	**0.59**	**5**	**14**	**5**	**24**	**0.026**	**0.025**
72265	Myelography, lumbosacral, radiological supervision and interpretation	0.83	5	15	5	25	0.040	0.033

MPC Codes

Our recommendation for surveyed code 73580 compares favorably to the MPC codes depicted in the table below. In comparison to MPC codes 74220 *(Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study)* and 76830

(Ultrasound, transvaginal), the value recommendation for CPT code 73580 has slightly higher intra-service and total times, but a similar work RVU. The surveyed code 73580 has 4 more minutes of intra-service time and 2 more minutes of total time when compared to MPC code 76519 *(Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation),* with a nearly identical recommended work RVU.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76519	Ophthalmic biometry by ultrasound echography, A-scan; with intraocular lens power calculation	0.54	2	10	10	22	0.027	0.025
73580	**Radiologic examination, knee, arthrography, radiological supervision and interpretation**	**0.59**	**5**	**14**	**5**	**24**	**0.026**	**0.025**
74220	Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study	0.60	3	10	3	16	0.047	0.038
76830	Ultrasound, transvaginal	0.69	5	10	8	23	0.040	0.030

Summary

In summary, our expert panel recommends the 25th survey percentile at 0.59 work RVU with survey median times of 5 minutes pre-service, 14 minutes intra-service, and 5 minutes post-service. The recommended value compares favorably with the key reference services, 72265 and 74022, and maintains relativity within the RBRVS.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: Yes

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   ☐ Multiple codes are used to maintain consistency with similar codes.
   ☐ Historical precedents.
   ☒ Other reason (please explain) The surveyed code is typically reported with the injection code 27369. However, these codes have a complicated history and CPT chose not to bundle these services due to the overlap of multiple associated codes which would require edits to 70+ codes.

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario. 73580 (RS&I for arthrography of the knee) is typically reported with 27369 (injection for arthrogram). We included 27369 as a reference code on the PE spreadsheet and were careful to avoid duplication of both physician work and PE inputs in our recommendations for 73580.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 73580

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Rarely

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 2060
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. This service described by CPT code 73580 is estimated to be provided 2,060 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 2060 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 687 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. 2019 utilization for CPT code 73580 is estimated around 29,300, of which Radiology is 2.3%. However, the top specialties indicated in the RUC DB (rheumatology, family medicine, orthopedic surgery, etc.,) indicate that they do not perform this procedure and there must be miscoding. Therefore, the service described by CPT code 73580 is estimated to be provided 687 times in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 687 Percentage 100.00 %

Specialty Frequency 0 Percentage 0.00 %

Specialty Frequency 0 Percentage 0.00 %

Do many physicians perform this service across the United States? Yes

Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:
Imaging/procedure

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix. 73722

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
1	**ISSUE:** Contrast X-Ray of Knee Joint																											
2	**TAB:** 16																											
3									RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
4	Source	CPT Code	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
5	1st REF	72265	XXX	Myelography, lumbosacral, radiological supervision and interpretation	Apr-14	26	0.040	0.033			0.83			25	5					15			5					
6	2nd REF	74022	XXX	Radiologic examination, complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, decubitus), and a single view chest	Apr-16	4	0.055	0.046			0.32			7	1					5			1					
7	CMS/Other	73580	XXX	Radiologic examination, knee, arthrography, radiological supervision and interpretation	Aug-95		0.000	0.000			0.54			12														
8	SVY - Combined	73580	XXX	Radiologic examination, knee, arthrography, radiological supervision and interpretation	Oct-21	41	0.040	0.033	0.22	0.59	0.79	0.83	1.20	24	5			3	8	14	16	45	5	0	0	3	10	100
9	SVY - Subset	73580	XXX	Radiologic examination, knee, arthrography, radiological supervision and interpretation		32	0.053	0.038	0.22	0.55	0.75	0.83	1.00	20	5			3	5	10	15	45	5	0	0	5	10	65
10	SVY - Random	73580	XXX	Radiologic examination, knee, arthrography, radiological supervision and interpretation		9	0.027	0.025	0.60	0.79	0.80	0.82	1.20	32	7			5	15	20	20	45	5	0	0	2	5	100
11	REC	73580	XXX	Radiologic examination, knee, arthrography, radiological supervision and interpretation			0.026	0.025			0.59			24	5					14			5					

SS Rec Summary

SAMPLE COMPLETED WORKSHEET

ISSUE: [TAB NAME]

TAB: 84

source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	RVW MIN	RVW 25th	RVW MED	RVW 75th	RVW MAX	Total Time	PRE EVAL	PRE POSIT	PRE SDW	INTRA MIN	INTRA 25th	INTRA MED	INTRA 75th	INTRA MAX	IMMD POST	FAC-inpt/same day 91	92	33	32	31	38	39	Office 15	14	13	12	11	SURVEY EXPERIENCE MIN	25th	MED	75th	MAX
1st REF	11111	000	xyz	2017	30	0.029	0.032			4.25			131	5	5	5			30			5				1	1.0			1									
2nd REF	22222	000	def	2011	15	0.055	0.038			5.15			137	10	5	5			35			5					1.0			1	1							
CURRENT	55555	000	abc	N/A - CMS/Other		0.053	0.038			5.00			133	17					27			8				1	1.0			1								
SVY	55555	000	abc		78	0.045	0.034	2.00	3.00	5.00	7.00	8.00	146	10	5	10	15	20	30	35	40	10				1	1.0			1					1	25	50	75	100
REC	55555	000	abc			0.020	0.030	4.25					142	17	1	3			30			10				1	1.0			1									

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 73580
SPECIALTY SOCIETY(IES): ACR
PRESENTER(S): Lauren Golding, MD; Andy Moriarity, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
73580	Radiologic examination, knee, arthrography, radiological supervision and interpretation	**XXX**

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
73580	A 55-year-old female with osteoarthritis of the knee is referred for radiologic examination following contrast injection into the joint (injection coded separately). Images from the procedure are interpreted.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The American College of Radiology convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for contrast x-ray of the knee joint.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   For our reference codes, the ACR is providing the current code as well as CPT codes 27369, 77002, and 73564, which are clinically similar to and/or included in the service described by CPT code 73580. CPT code 27369 describes the injection procedure performed for the arthrogram and was included to ensure there was no duplication of PE inputs between this code and the surveyed code. The surveyed code can be thought of as a combination of the other two reference codes, 77002 and 73564. CPT code 77002 describes the fluoroscopic guidance for the arthrogram, which is part of the surveyed code (unlike in the case of CT or MR arthrography in which the fluoroscopic guidance is billed separately). CPT code 73564 describes an x-ray exam of the knee, which is clinically similar to the interpretation component of the surveyed RS&I code.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see the *Billed Together* tab in the RUC Database)

   CPT code 73580 is typically reported with an E/M service at 62.3%.
   CPT code 73580 is typically reported with an E/M service in the nonfacility at 63.3%.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see the *Billed Together* tab in the RUC Database)

   According to the RUC database in the non-facility (Global & 26), Rheumatology is the dominant specialty at 20%. Rheumatology is also the dominant specialty for the global (all sites) at 19.6%.

However, Rheumatology has indicated that they believe this to be an error due to possible miscoding. We believe Radiology should be the dominant provider for this procedure.

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

N/A.

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No.

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

N/A.

8. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

The following clinical activities, totaling 17 minutes, have been rolled into CA021 "Perform procedure/service –NOT directly related to physician time." The specialty is only recommending 12 minutes for CA021.

- (OLD) Assist physician in performing procedure- Acquire images (scout radiographs): 6 minutes
- (OLD) Review scout radiographs with physician: 1 minute
- (OLD) Assist physician in performing procedure- Obtain post injection radiographs: 10 minutes

9. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A.

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

Confirm availability of prior images. Review clinical history and questionnaire.

b. Service period (includes pre, intra and post):

Prepare room and equipment. Position patient. Obtain and review scout images (typically 2). Operate or assist physician with operation of fluoroscopic equipment. Obtain post-injection images (typically 4).

c. Post-service period:

Clean room/equipment. QC images in PACS. Review exam with interpreting MD. Scan documents into PACS. Complete exam in RIS system.

11. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

Bring patient into x-ray room and have patient sit/lie on x-ray table. Place first cassette behind patient's knee. Position patient's anatomy for the scout view. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for first view. Step from behind shielding. Take first cassette from behind patient and place second cassette as needed. Position patient's anatomy for lateral view. Step behind shielding to control panel. Set appropriate exposure parameters. Instruct patient to hold still. Take exposure for second view (typically 2). Step from behind shielding. Take second cassette out behind patient. Run all cassettes through reader. Check all images for adequate exposure, positioning, coverage, etc. Repeat any views as needed. Operate or assist physician with operation of the fluoroscopic equipment during the injection of contrast. Repeat the steps for radiograph acquisition above for the post-injection views (typically 4). Run all cassettes through reader. Check all images for adequate exposure, positioning, coverage, etc. Repeat any views as needed.

Note: Radiology codes typically assume 2 minutes of technologist time required to obtain radiographs of appendicular structures (e.g. the knee). The 12 minutes for CA021 accounts for 2 minutes to obtain each of the typical 2 scout images and 4 post-injection radiographs included in 73580.

12. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.

N/A.

13. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):

N/A.

14. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.

N/A.

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 73580

SPECIALTY SOCIETY(IES): ACR

PRESENTER(S): Lauren Golding, MD; Andy Moriarity, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:

N/A.

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?

No.

19. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A.

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A.

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A.

22. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A.

23. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time).* If you have selected "other formula" for any of the equipment please explain here:

- **Technologist PACS workstation (ED050)** = PACS formula
- **Professional PACS workstation (ED053)** = Sum of half of pre-service physician time and full intra-service physician time
- **Room, radiographic-fluoroscopic (EL014)** = Highly technical formula

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 73580

SPECIALTY SOCIETY(IES): ACR

PRESENTER(S): Lauren Golding, MD; Andy Moriarity, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

NONFACILITY DIRECT PE INPUTS

CPT CODE(S): 73580

SPECIALTY SOCIETY(IES): ACR

PRESENTER(S): Lauren Golding, MD; Andy Moriarity, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC)
PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

N/A.

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	I	K	M	O
1	RUC Practice Expense Spreadsheet					REFERENCE CODE	REFERENCE CODE	REFERENCE CODE	CURRENT	RECOMMENDED
2						27369	77002	73564	73580	73580
3		***RUC Collaboration Website***				Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	Radiologic examination, knee; complete, 4 or more views	Radiologic examination, knee, arthrography, radiological supervision and interpretation	Radiologic examination, knee, arthrography, radiological supervision and interpretation
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 16 Specialty: ACR**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	**(October 2017)**	**(October 2017) (under review for October 2021)**	**(September 2014)**	**(January 2004)**	**(October 2021)**
5		**LOCATION**				**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
6		**GLOBAL PERIOD**				**000**	**ZZZ**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**				**31.0**	**29.0**	**23.0**	**32.0**	**28.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L041B			**0.0**	**4.0**	**0.0**	**0.0**	**4.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L041B			**31.0**	**25.0**	**23.0**	**32.0**	**24.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L041B			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x**				**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**								
14		**Start: Following visit when decision for surgery/procedure made**								
15	CA001									
16	CA002									
17	CA003									
18	CA004									
19	CA005									
20	CA006		L041B				**2**			**2**
21	CA007		L041B				**2**			**2**
22	CA008									
29		**End: When patient enters office/facility for surgery/procedure**								
30		**SERVICE PERIOD**								
31		**Start: When patient enters office/facility for surgery/procedure:**								
32		**Pre-Service (of service period)**								
33	CA009		L041B			**3**		**3**		
34	CA010									
35	CA011		L041B			**3**				
36	CA012									
37	CA013		L041B			**3**		**2**		**2**
38	CA014									
39	CA015									
40	CA016		L041B			**2**	**2**	**2**		**2**
41	CA017									
42	*OLD*	Obtain prior radiographs/Review protocol with	L041B						**3**	
43	*OLD*	Prepare imaging equipment	L041B						**1**	
48		**Intra-service (of service period)**								
49	CA018		L041B			**15**	**15**			
50	CA019									
51	CA020		L041B					**8**		
52	CA021		L041B							**12**
53	*OLD*	Assist physician in performing procedure - Acquire images (scout radiographs)	L041B						**6**	
54	*OLD*	Review scout radiographs with physician	L041B						**1**	
55	*OLD*	Assist physician in performing procedure - Obtain post injection radiographs	L041B						**10**	
59		**Post-Service (of service period)**								
60	CA022									
61	CA023									
62	CA024		L041B			**3**	**3**	**3**		**3**
63	CA025									
64	CA026									
65	CA027									

	A	B	D	E	F	G	I	K	M	O
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**	**REFERENCE CODE**	**REFERENCE CODE**	**CURRENT**	**RECOMMENDED**
2						**27369**	**77002**	**73564**	**73580**	**73580**
3		***RUC Collaboration Website***				Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography	Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)	Radiologic examination, knee; complete, 4 or more views	Radiologic examination, knee, arthrography, radiological supervision and interpretation	Radiologic examination, knee, arthrography, radiological supervision and interpretation
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 16 Specialty: ACR**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**	**(October 2017)**	**(October 2017) (under review for October 2021)**	**(September 2014)**	**(January 2004)**	**(October 2021)**
5		**LOCATION**				**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**	**Non Fac**
6		**GLOBAL PERIOD**				**000**	**ZZZ**	**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				$ -	$ -	$ -	$ -	$ -
8		**TOTAL CLINICAL STAFF TIME**				**31.0**	**29.0**	**23.0**	**32.0**	**28.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L041B			**0.0**	**4.0**	**0.0**	**0.0**	**4.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L041B			**31.0**	**25.0**	**23.0**	**32.0**	**24.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L041B			**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
66	CA028									
67	CA029									
68	CA030		L041B				**2**	**2**		**2**
69	CA031		L041B				**2**	**2**		**2**
70	CA032		L041B				**1**	**1**		**1**
71	CA033									
72	CA034									
73	CA035		L041B			**2**				
74	CA036					**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
75	*OLD*	Clean room and x-ray equipment	L041B						**2**	
76	*OLD*	Other Clinical Activity: Process films, hang	L041b						**9**	
80		**End: Patient leaves office/facility**								
81		**POST-SERVICE PERIOD**								
98		**End: with last office visit before end of**								
99	**Supply Code**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**						
100		**TOTAL COST OF SUPPLY QUANTITY x PRICE**				$ -	$ -	$ -	$ -	$ -
101	SA060					**1**				
102	SB008						**1**			
103	SB022					**1**	**1**			
104	SB024					**1**				
105	SB026							**1**		
106	SH021					**10**				
107	SH068					**1**				
108	SJ041					**30**				
109	SM013						**1**			
112	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**					
113		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				$ -	$ -	$ -	$ -	$ -
114	ED050			PACS			**25**	**23**	**32**	**24**
115	ED053			Other Formula				**6**	**6**	**17**
116	EL014			Highly Technical		**23**	**22**		**32**	**19**
117	EL012			Other Formula				**17**		

AMA/Specialty Society RVS Update Committee Summary of Recommendations
CMS Request – Final Rule for 2021

October 2021

3D Rendering with Interpretation and Report – Tab 17

In the Final Rule for the CY 2020 Medicare Physician Fee Schedule, CMS nominated CPT code 76377 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation* as potentially misvalued. The Agency views CPT code 76377 to be part of the same family as CPT code 76376 *3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation*, which was recently reviewed at the April 2018 RUC meeting. CMS requested that CPT code 76377 also be reviewed to maintain relativity within the code family.

The specialty societies surveyed CPT code 76377, as requested by CMS, yet disagree with the Agency's rationale for the nomination of the code as potentially misvalued, as they still do not believe that CPT codes 76376 and 76377 are part of the same code family. During discussion of CPT code 76376 in April 2018, it was noted that "CPT code 76377 was not surveyed for the April 2018 RUC meeting with 76376 for several reasons. CPT code 76376 is performed by technologists on the diagnostic workstation for a wide variety of clinical exams with the images subsequently interpreted by the radiologist to answer specific clinical questions at the request of the referring physician. CPT code 76377 is for technically demanding reconstructions typically performed by the radiologist on an independent workstation. These are much more involved data reconstructions on a few specific types of exams. The patient population undergoing CPT code 76376 is much different than the 76377 code."

At the October 2021 meeting, the family for CPT codes 76376 and 76377 was questioned again. The specialty societies resolutely maintain that these two services are not a code family. CPT code 76377 involves the creation of 3D reconstructions of the organs of interest using an independent workstation, requiring complex software post processing, such as for surface rendering or tractography. This specialized hardware and software is never utilized when performing the work of 76376. Despite similar descriptors, the societies emphasized that the two codes are different due to the different clinical indications for each code, different patient populations, and fundamental differences in both the equipment needed to perform the work and the type of provider that performs the rendering. The typical patient for 76377 is a patient with a renal cell carcinoma and those patients where the surgeons are considering nephron-sparing surgery. Code 76377 is used for very intricate detailing of the tumor for pre-surgical planning. It is important to isolate the tumor and discern the relationship between the vessels, requiring more time and effort on the physician's part than for code 76376. It was further noted that the technical and professional resources required for 76376 and 76377 are significantly different. The specialties maintained that the physician work required for these two services is inherently different and not part of the same family.

Compelling Evidence
The specialty societies chose to address compelling evidence, although not required, in order to support their recommendation for maintaining the current value of CPT code 76377 despite decreases in intra-service and immediate post-service time. The argument for compelling evidence was based upon a change in technique and patient population. CPT code 76377 was last reviewed in 2005 when 3D rendering was first becoming a possibility in routine clinical care. Over the intervening years, there have been many changes in both the quality of the source imaging (e.g., increasing use of multiparametric and dynamic MRI, thinner slice CT source images, etc.) and the capabilities of postprocessing software. These changes have allowed for finer anatomical detail and have increased the requirements and expectations of ordering clinicians. Additionally, there has been a significant increase in patients eligible for nephron-sparing surgery for renal cell carcinoma since 2005. With modern treatment options, accurate and detailed 3D rendering is now a more significant component of surgical planning. The RUC reviewed and agreed that there has been a significant increase in imaging technology since the code was initially valued in 2005, including an increase in the number and complexity of software programs that can be used to reformat the types of imaging and an increase in the number and quantity of data obtained from the source imaging. The significant changes in technology (dynamic MRI, multi parametric MRI, and more advanced CT imaging), and creation and review of these images, results in more complexity overall in performing this code. **The RUC concurred that there is compelling evidence that the physician work for this service has changed due to a change in technique.** Although the recommendation does not request an increase in value, compelling evidence was established to justify the decreases in time and establish an increase in intensity and complexity.

76377 ***3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation***
The RUC reviewed the survey results from 53 radiologists and neuroradiologists and determined that maintaining the current work RVU of 0.79, which falls below the survey 25th percentile, appropriately accounts for the physician work involved in this service. The RUC recommends 5 minutes pre-service evaluation time, 15 minutes intra-service time and 5 minutes post-service time as supported by the survey. As referenced above, the technology and expectations for performing this service have changed since it was last valued in 2005. As a result, the RUC believes that maintaining work value while slightly lowering total time is appropriate given the increase in intensity. The specialty asserted that the survey respondents accurately identified that this service has seen some increase in work efficiency and time based on improvements in postprocessing workflow but that the intensity and complexity of the work has increased.

The RUC compared CPT code 76377 to the top key reference code 71270 *Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections* (work RVU = 1.25, 5 minutes pre-service evaluation time, 18 minutes intra-service time and 4 minutes immediate post-service time) and noted that the surveyed code has slightly less intra-service time and is less intense than the reference code and therefore is appropriately valued lower. The RUC also compared 76377 to the second top key reference code 70450 *Computed tomography, head or brain; without contrast material* (work RVU = 0.85, 4 minutes pre-service evaluation time, 10 minutes intra-service time and 4 minutes immediate post-service time) and noted that the surveyed code has more intra-service time yet is much less intense than the reference code and therefore is appropriately valued lower.

For additional support, the RUC compared CPT code 76377 to MPC codes 74246 *Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered* (work RVU = 0.90, 4 minutes pre-service evaluation time, 15 minutes intra-service time and 3 minutes

immediate post-service time) and 95819 *Electroencephalogram (EEG); including recording awake and asleep* (work RVU = 1.08, 5 minutes pre-service evaluation time, 15 minutes intra-service time and 6 minutes immediate post-service time) and noted that the multi-specialty points of comparison values have identical intra-service time and are both more intense than the surveyed code, justifying the recommendation. The RUC concluded that the value of CPT code 76377 should be maintained at 0.79 work RVUs, below the 25th percentile of the survey. **The RUC recommends a work RVU of 0.79 for CPT code 76377.**

Practice Expense

The Practice Expense (PE) Subcommittee discussed and accepted the compelling evidence argument that this service has changed based on change in technology and patient population. CPT code 76377 was last reviewed by the RUC in 2005. In the past 16 years, there have been significant changes in both technology and patient population. Specifically, the number and complexity of available post-processing software packages has increased since 2005, requiring more time to reconstruct and review images. The change in patient population is based largely on the typical patient who has a renal cell carcinoma which now, since the code was originally surveyed, can be treated with nephron-sparing surgery; therefore, this code is now used for very intricate detailing of the tumor for pre surgical planning. These changes have resulted in increased times for this service. There have also been changes in RUC methodology with standardization of times for practice expense inputs since the code was last valued. In addition, the current equipment inputs for this code erroneously omit a professional PACS workstation. However, the work of this service includes dictating the report, which is done on a professional PACS workstation and therefore 18 minutes are recommended based on the professional PACS formula. **The RUC recommends the direct practice expense inputs as submitted by the specialty society.**

CPT Code	CPT Descriptor	Global Period	Work RVU Recommendation
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	XXX	0.79 (No Change)

AMA/SPECIALTY SOCIETY RVS UPDATE PROCESS
SUMMARY OF RECOMMENDATION

CPT Code:76377 Tracking Number Original Specialty Recommended RVU: **0.79**
Presented Recommended RVU: **0.79**
Global Period: XXX Current Work RVU: **0.79** RUC Recommended RVU: **0.79**

CPT Descriptor: 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation

CLINICAL DESCRIPTION OF SERVICE:

Vignette Used in Survey: A 50-year-old male presented to his physician with hematuria. Renal ultrasound (coded separately) identified a 3-cm lower pole right renal mass consistent with renal cell carcinoma, previously diagnosed with ultrasound. The patient is a possible candidate for nephron-sparing partial nephrectomy. A CT scan of the abdomen is ordered by the patient's urologist. Three-dimensional rendering is requested for further evaluation. A CT examination of the abdomen, both before and after the use of contrast media, is performed (coded separately). Subsequent postprocessing and 3D reconstruction is performed demonstrating the patient is a candidate for partial nephrectomy.

Percentage of Survey Respondents who found Vignette to be Typical: 72%

Site of Service (Complete for 010 and 090 Globals Only)

Percent of survey respondents who stated they perform the procedure; In the hospital 0% , In the ASC 0%, In the office 0%

Percent of survey respondents who stated they typically perform this procedure in the hospital, stated the patient is; Discharged the same day 0% , Overnight stay-less than 24 hours 0% , Overnight stay-more than 24 hours 0%

Percent of survey respondents who stated that if the patient is typically kept overnight also stated that they perform an E&M service later on the same day 0%

Description of Pre-Service Work: Review protocol with technologist. Review any prior imaging studies. Review source imaging data.

Description of Intra-Service Work: Supervise and/or create 3D reconstructions of the organs of interest using an independent workstation. Adjust the projection of the 3D reconstructions to optimize visualization of anatomy or pathology. Interpret the 3D reformatted images resulting from the study, typically including cine review. Compare to all pertinent available prior studies. Dictate report for medical record.

Description of Post-Service Work: Review and sign report. Communicate results to the referring physician and the patient, when appropriate.

SURVEY DATA

RUC Meeting Date (mm/yyyy)	10/2021		
Presenter(s):	Lauren Golding, MD; Andy Moriarity, MD; Melissa Chen, MD; Ryan Lee, MD		
Specialty Society(ies):	ACR, ASNR		
CPT Code:	76377		
Sample Size:	3650	**Resp N:**	53
Description of Sample:	The ACR surveyed a total of 1,250 members (a random sample of 625 members and a separate random sample of 625 members who perform abdominal imaging, gastrointestinal, genitourinary, neuro imaging, neurointerventional, thoracic, and interventional radiology procedures). The ASNR surveyed a random sample of 2,400 from its membership.		

	Low	25th pctl	Median*	75th pctl	High
Service Performance Rate	2.00	24.00	**50.00**	150.00	5000.00
Survey RVW:	0.26	0.85	**1.10**	1.35	1.65
Pre-Service Evaluation Time:			**5.00**		
Pre-Service Positioning Time:			**0.00**		
Pre-Service Scrub, Dress, Wait Time:			**0.00**		
Intra-Service Time:	2.00	10.00	**15.00**	18.00	45.00

Immediate Post Service-Time:	**5.00**	
Post Operative Visits	**Total Min****	**CPT Code and Number of Visits**
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.00** 99239x **0.00** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

**Physician standard total minutes per E/M visit: 99291 (70); 99292 (30); 99231 (20); 99232 (40); 99233 (55); 99238(38); 99239 (55); 99217 (38); 99211 (7); 99212 (16); 99213 (23); 99214 (40); 99215 (55); 99224 (20); 99225 (40); 99226 (55); 99354 (60); 99355 (30); 99356 (60); 99357 (30)

Specialty Society Recommended Data

Please, pick the pre-service time package that best corresponds to the data which was collected in the survey process. (Note: your recommended pre time should not exceed your survey median time for any category)

XXX Global Code

CPT Code:	76377	**Recommended Physician Work RVU: 0.79**		
		Specialty Recommended Pre-Service Time	**Specialty Recommended Pre Time Package**	**Adjustments/Recommended Pre-Service Time**
Pre-Service Evaluation Time:		**5.00**	**0.00**	**0.00**
Pre-Service Positioning Time:		**0.00**	**0.00**	**0.00**
Pre-Service Scrub, Dress, Wait Time:		**0.00**	**0.00**	**0.00**
Intra-Service Time:		**15.00**		

Please, pick the post-service time package that best corresponds to the data which was collected in the survey process: (Note: your recommended post time should not exceed your survey median time)

XXX Global Code

	Specialty Recommended Post-Service Time	**Specialty Recommended Post Time Package**	**Adjustments/Recommended Post-Service Time**

Immediate Post Service-Time:	**5.00**	**0.00**	**0.00**

Post-Operative Visits	Total Min**	CPT Code and Number of Visits
Critical Care time/visit(s):	**0.00**	99291x **0.00** 99292x **0.00**
Other Hospital time/visit(s):	**0.00**	99231x **0.00** 99232x **0.00** 99233x **0.00**
Discharge Day Mgmt:	**0.00**	99238x **0.0** 99239x **0.0** 99217x **0.00**
Office time/visit(s):	**0.00**	99211x **0.00** 12x **0.00** 13x **0.00** 14x **0.00** 15x **0.00**
Prolonged Services:	**0.00**	99354x **0.00** 55x **0.00** 56x **0.00** 57x **0.00**
Sub Obs Care:	**0.00**	99224x **0.00** 99225x **0.00** 99226x **0.00**

Modifier -51 Exempt Status
Is the recommended value for the new/revised procedure based on its modifier -51 exempt status? No

New Technology/Service:
Is this new/revised procedure considered to be a new technology or service? No

TOP KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
71270	XXX	1.25	**RUC Time**

CPT Descriptor Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections

SECOND HIGHEST KEY REFERENCE SERVICE:

Key CPT Code	Global	Work RVU	Time Source
70450	XXX	0.85	**RUC Time**

CPT Descriptor Computed tomography, head or brain; without contrast material

KEY MPC COMPARISON CODES:
Compare the surveyed code to codes on the RUC's MPC List. Reference codes from the MPC list should be chosen, if appropriate that have relative values higher and lower than the requested relative values for the code under review.

MPC CPT Code 1	Global	Work RVU	Time Source	Most Recent Medicare Utilization
74246	XXX	0.90	**RUC Time**	34,438

CPT Descriptor 1 Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered

MPC CPT Code 2	Global	Work RVU	Time Source	Most Recent Medicare Utilization
95819	XXX	1.08	**RUC Time**	202,028

CPT Descriptor 2 Electroencephalogram (EEG); including recording awake and asleep

Other Reference CPT Code	Global	Work RVU	Time Source
		0.00	

CPT Descriptor

RELATIONSHIP OF CODE BEING REVIEWED TO TOP TWO KEY REFERENCE SERVICES:
Compare the pre-, intra-, and post-service time (by the median) and the intensity factors (by percent distribution) of the service you are rating to the top two chosen key reference services listed above. **Make certain that you are including existing time data (RUC if available, Harvard if no RUC time available) for the reference code listed below.**

Number of respondents who choose Top Key Reference Code: 18 **% of respondents:** 33.9 **%**

Number of respondents who choose 2nd Key Reference Code: 13 **% of respondents:** 24.5 **%**

TIME ESTIMATES (Median)

	CPT Code: 76377	Top Key Reference CPT Code: 71270	2nd Key Reference CPT Code: **70450**
Median Pre-Service Time	5.00	5.00	4.00
Median Intra-Service Time	15.00	18.00	10.00
Median Immediate Post-service Time	5.00	4.00	4.00
Median Critical Care Time	0.0	0.00	0.00
Median Other Hospital Visit Time	0.0	0.00	0.00
Median Discharge Day Management Time	0.0	0.00	0.00
Median Office Visit Time	0.0	0.00	0.00
Prolonged Services Time	0.0	0.00	0.00
Median Subsequent Observation Care Time	0.0	0.00	0.00
Median Total Time	**25.00**	**27.00**	**18.00**
Other time if appropriate			

INTENSITY/COMPLEXITY MEASURES
(of those that selected Key Reference codes)

Survey respondents are rating the survey code relative to the key reference code.

Survey Code Compared to Top Key Reference Code	Much Less	Somewhat Less	Identical	Somewhat More	Much More
Overall intensity/complexity	0%	0%	6%	67%	28%

Mental Effort and Judgment	Less	Identical	More
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	6%	22%	72%

Technical Skill/Physical Effort	Less	Identical	More
Technical skill required	0%	17%	83%

Physical effort required	0%	56%	44%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	0%	22%	78%

Survey Code Compared to 2nd Key Reference Code	**Much Less**	**Somewhat Less**	**Identical**	**Somewhat More**	**Much More**
Overall intensity/complexity	0%	23%	31%	46%	0%

Mental Effort and Judgment	**Less**	**Identical**	**More**
• The number of possible diagnosis and/or the number of management options that must be considered • The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed • Urgency of medical decision making	23%	31%	46%

Technical Skill/Physical Effort	**Less**	**Identical**	**More**
Technical skill required	8%	31%	62%
Physical effort required	8%	62%	31%

Psychological Stress	**Less**	**Identical**	**More**
• The risk of significant complications, morbidity and/or mortality • Outcome depends on the skill and judgment of physician • Estimated risk of malpractice suit with poor outcome	23%	46%	31%

Additional Rationale and Comments

Describe the process by which your specialty society reached your final recommendation. *If your society has used an IWPUT analysis, please refer to the Instructions for Specialty Societies Developing Work Relative Value Recommendations for the appropriate formula and format.*

The additional rationale below is the original rationale submitted by the specialty society(ies) prior to the RUC meeting and does not necessarily represent the rationale for the RUC recommendation. To view the RUC's rationale, please review the separate RUC recommendation document.

Background

In the Final Rule for the CY 2020 Medicare Physician Fee Schedule, CMS nominated CPT code 76377 *(3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision;*

requiring image postprocessing on an independent workstation) as potentially misvalued. The Agency viewed CPT code 76377 to be part of the same family as CPT code 76376 *(3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation)*, which was recently reviewed at the April 2018 RUC meeting. CMS requested that CPT code 76376 also be reviewed to maintain relativity within the code family. The specialty societies disagreed with CMS' rationale for the nomination of CPT code 76377 as potentially misvalued and the specialties do not believe that CPT codes 76376 and 76377 are in the same code family, although the descriptors are similar. The societies noted that the two codes are different because they are utilized on different patient populations (as evidenced by the ICD-10 diagnoses). They also noted that the technical and professional resources required for 76376 and 76377 are significantly different. For these reasons, the specialty societies recommended, and the RUC agreed to refer CPT codes 76377 and 76376 to the CPT Editorial Panel for further review and potential revision. The specialty societies noted that they will determine the family of services including whether the codes remain a family, based on the recommendations of the CPT Editorial Panel**.** In February 2021, the specialty society notified AMA staff that they will not bring a CCA to CPT. As this was a CMS request on the October 2021 LOI, the American College of Radiology (ACR) and American Society of Neuroradiology (ASNR) agreed to survey CPT code 76377 for the October 2021 RUC meeting.

Survey Process
The ACR surveyed a total of 1,250 members (a random sample of 625 members and a separate random sample of 625 members who perform abdominal imaging, gastrointestinal, genitourinary, neuro imaging, neurointerventional, thoracic, and interventional radiology procedures). The ASNR surveyed a random sample of 2,400 individuals from its membership.

Compelling Evidence
The societies believe that there is compelling evidence to consider an increase in the value for CPT code 76377 based on: technique and knowledge/technology. CPT code 76377 was last updated in 2005 when 3D rendering was first becoming a possibility in routine clinical care. Over the intervening years, there have been many changes in both the quality of the source imaging (e.g., increasing use of multiparametric and dynamic MRI, thinner slice CT source images, etc.) and the capabilities of postprocessing software. These changes have allowed for finer anatomical detail and have increased the requirements and expectations of ordering clinicians. It should be noted that 72% of respondents agreed with the vignette that a partial nephrectomy evaluation is the typical clinical situation. Throughout the years, renal cell carcinoma has been described in literature as becoming the "radiologists' tumor rather than the internists'" [1] and AUA Guidelines have concluded that compelling data exists for consideration of nephron-sparing surgery in all patients [2]. This has led to changes in the inclusion criteria for partial nephrectomy evaluation and the requisite complexity of technology needed to adequately guide surgical intervention.

Work RVU and Time Recommendations
The expert panel recommends maintaining the current value at 0.79 work RVU and survey median times of 5 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service. As referenced above, the technology and expectations of performing this service have changed since it was last valued in 2005. As a result, the societies believe that maintaining work value while lowering total time is appropriate despite an increase in IWPUT. We believe our survey respondents have accurately identified that this service has seen some increase in work efficiency and time based on improvements in postprocessing workflow but that the intensity and complexity of the work has increased.

Key Reference Services
In comparison to the first key reference service CPT code 71270, the surveyed code's work RVU of 0.79 and IWPUT of 0.038 compares favorably, as individual and overall components of intensity and complexity were surveyed higher for the surveyed code than in the key reference service. In comparison to the second key reference service CPT code 70450, the surveyed code's work RVU of 0.79 and IWPUT of 0.038 compares

favorably, as individual and overall components of intensity and complexity were surveyed higher for the surveyed code than in the key reference service. It should be noted that our recommendations would place this service below the work RVU, IWPUT, and WPUT of both key reference services despite being surveyed as more intense and complex.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76377	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation**	**0.79**	**5**	**15**	**5**	**25**	**0.038**	**0.032**
70450	Computed tomography, head or brain; without contrast material	0.85	4	10	4	18	0.067	0.047
71270	Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections	1.25	5	18	4	27	0.058	0.046

MPC Codes

CPT code 76377 compares favorably with MPC codes 74246 and 95819. All three codes share identical intra-service times and similar pre- and post- times respectively, with CPT code 76377 having the lowest work RVU and IWPUT amongst the three codes.

CPT Code	Descriptor	Work RVU	Pre	Intra	Post	Total Time	IWPUT	WPUT
76377	**3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation**	**0.79**	**5**	**15**	**5**	**25**	**0.038**	**0.032**
74246	Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered	0.90	4	15	3	22	0.050	0.041
95819	Electroencephalogram (EEG); including recording awake and asleep	1.08	5	15	6	26	0.056	0.042

Summary

In summary, our expert panel recommends maintaining the current value at 0.79 work RVU and survey median times of 5 minutes pre-service, 15 minutes intra-service, and 5 minutes post-service. The recommended value compares favorably with the key reference services, 71270 and 70450, and maintains relativity within the RBRVS.

References

1) Semin Intervent Radiol. 2014 Mar; 31(1): 104–106.
2) J Urol. 2009 Oct;182(4):1271-9.

SERVICES REPORTED WITH MULTIPLE CPT CODES

1. Is this code typically reported on the same date with other CPT codes? If yes, please respond to the following questions: No

   Why is the procedure reported using multiple codes instead of just one code? (Check all that apply.)

   - ☐ The surveyed code is an add-on code or a base code expected to be reported with an add-on code.
   - ☐ Different specialties work together to accomplish the procedure; each specialty codes its part of the physician work using different codes.
   - ☐ Multiple codes allow flexibility to describe exactly what components the procedure included.
   - ☐ Multiple codes are used to maintain consistency with similar codes.
   - ☐ Historical precedents.
   - ☐ Other reason (please explain)

2. Please provide a table listing the typical scenario where this code is reported with multiple codes. Include the CPT codes, global period, work RVUs, pre, intra, and post-time for each, summing all of these data and accounting for relevant multiple procedure reduction policies. If more than one physician is involved in the provision of the total service, please indicate which physician is performing and reporting each CPT code in your scenario.

FREQUENCY INFORMATION

How was this service previously reported? (if unlisted code, please ensure that the Medicare frequency for this unlisted code is reviewed) 76377

How often do physicians in your specialty perform this service? (ie. commonly, sometimes, rarely)
If the recommendation is from multiple specialties, please provide information for each specialty.

Specialty Diagnostic Radiology How often? Commonly

Specialty How often?

Specialty How often?

Estimate the number of times this service might be provided nationally in a one-year period? 571029
If the recommendation is from multiple specialties, please provide the frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 76377 is estimated to be provided 571,029 times nationally in a one-year period.

Specialty Diagnostic Radiology Frequency 435695 Percentage 76.30 %

Specialty Cardiology Frequency 42827 Percentage 7.50 %

Specialty Urology Frequency 17130 Percentage 3.00 %

Estimate the number of times this service might be **provided to Medicare patients** nationally in a one-year period? 190,343 If this is a recommendation from multiple specialties please estimate frequency and percentage for each specialty. Please explain the rationale for this estimate. The service described by CPT code 76377 is estimated to be provided 190,343 times nationally in a one-year period to Medicare patients.

Specialty Diagnostic Radiology Frequency 145231 Percentage 76.30 %

Specialty Cardiology Frequency 14275 Percentage 7.50 %

Specialty Urology Frequency 5710 Percentage 3.00 %

Do many physicians perform this service across the United States? Yes

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Berenson-Eggers Type of Service (BETOS) Assignment

Please pick the appropriate BETOS classification that best corresponds to the clinical nature of this CPT code. Please select the main BETOS classification and sub-classification to the greatest level of specificity possible.

Main BETOS Classification:
Imaging

BETOS Sub-classification:

BETOS Sub-classification Level II:
Other

Professional Liability Insurance Information (PLI)

If the surveyed code is an existing code and the specialty believes the specialty utilization mix will not change, enter the surveyed existing CPT code number 76377

If this code is a new/revised code or an existing code in which the specialty utilization mix will change, please select another crosswalk based on a similar specialty mix.

SS Rec Summary

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	AR	AS	AT	AU	AV
1	**ISSUE:** 3D Rendering with Interpretation & Report																											
2	**TAB:** 17																											
3									RVW					Total	PRE-TIME			INTRA-TIME					IMMD	SURVEY EXPERIENCE				
4	Source	CPT	Global	DESC	RUC Review Year	Resp	IWPUT	Work Per Unit Time	MIN	25th	MED	75th	MAX	Time	EVAL	POSIT	SDW	MIN	25th	MED	75th	MAX	POST	MIN	25th	MED	75th	MAX
5	1st REF	71270	XXX	Computed tomography, thorax, diagnostic; without contrast material, followed by contrast material(s) and further sections	Oct-19	18	0.058	0.046			1.25			27	5					18			4					
6	2nd REF	70450	XXX	Computed tomography, head or brain; without contrast material	Apr-19	13	0.067	0.047			0.85			18	4					10			4					
7	CURRENT	76377	XXX	3D rendering with interpretation and reporting of computed tomography, magnetic resonance	Apr-05		0.029	0.026			0.79			30	5					17			8					
8	SVY - Combined	76377	XXX	3D rendering with interpretation and reporting of computed tomography, magnetic resonance	Oct-21	53	0.058	0.044	0.26	0.85	1.10	1.35	1.65	25	5			2	10	15	18	45	5	2	24	50	150	5000
9	SVY - ACR Combined	76377	XXX	3D rendering with interpretation and reporting of computed tomography, magnetic resonance		23	0.050	0.039	0.63	0.90	1.20	1.48	1.65	31	8			10	10	18	20	45	5	4	20	30	100	5000
10	SVY - ACR Subset	76377	XXX	3D rendering with interpretation and reporting of computed tomography, magnetic resonance		19	0.043	0.032	0.63	0.85	1.00	1.38	1.65	31	10			10	10	15	20	45	6	4	18	30	75	5000
11	SVY - ACR Random	76377	XXX	3D rendering with interpretation and reporting of computed tomography, magnetic resonance		4	0.054	0.044	0.95	1.33	1.48	1.54	1.65	34	7			12	18	23	25	25	4	25	44	97	171	250
12	SVY - ASNR	76377	XXX	3D rendering with interpretation and reporting of computed tomography, magnetic resonance		30	0.087	0.058	0.26	0.78	1.05	1.20	1.50	18	3			2	9	10	15	45	5	2	30	100	188	720
13	REC	76377	XXX	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation			0.038	0.032			0.79			25	5					15			5					

NONFACILITY DIRECT PE INPUTS **CPT CODE(S): 76377**

SPECIALTY SOCIETY(IES): ACR, ASNR

PRESENTER(S):

Lauren Golding, MD; Andrew Moriarity, MD; Melissa Chen, MD; Ryan Lee, MD

AMA/SPECIALTY SOCIETY RELATIVE VALUE UPDATE COMMITTEE (RUC) PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Meeting Date: October 2021

CPT Code	Long Descriptor	Global Period
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	XXX

Vignette(s) (*vignette required even if PE only code(s)***):**

CPT Code	Vignette
76377	A 50-year-old male presented to his physician with hematuria. Renal ultrasound (coded separately) identified a 3-cm lower pole right renal mass consistent with renal cell carcinoma, previously diagnosed with ultrasound. The patient is a possible candidate for nephron-sparing partial nephrectomy. A CT scan of the abdomen is ordered by the patient's urologist. Three-dimensional rendering is requested for further evaluation. A CT examination of the abdomen, both before and after the use of contrast media, is performed (coded separately). Subsequent postprocessing and 3D reconstruction is performed demonstrating the patient is a candidate for partial nephrectomy.

1. Please provide a brief description of the process used to develop your recommendation and the composition of your Specialty Society RVS Committee Expert Panel:

   The American College of Radiology and the American Society of Neuroradiology convened a panel that included a number of experts familiar with this service to evaluate the direct practice expense inputs for this procedure.

2. Please provide reference code(s) for comparison on your spreadsheet. If you are making recommendations on an existing code, you are required to use the current direct PE inputs as your reference code but may provide an additional reference code for support. Provide an explanation for the selection of reference code(s) here (NOTE: *For services reviewed prior to the implementation of clinical activity codes, detail is not provided in the RUC database, please contact Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org for PE spreadsheets for your reference codes*):

   The specialties will be using the current inputs for CPT code 76377 as the reference code for our proposed inputs. Although the specialties do not consider CPT codes 76376 and 76377 to be a code family due to differences in clinical nature as well as patient populations, we included CPT code 76376 as a reference code per AMA staff request.

3. Is this code(s) typically reported with an E/M service?
   Is this code(s) typically reported with the E/M service in the nonfacility?
   (Please see the *Billed Together* tab in the RUC Database)

   No, this code is not typically reported with an E/M.

4. What specialty is the dominant provider in the nonfacility?
   What percent of the time does the dominant provider provide the service(s) in the nonfacility?
   Is the dominant provider in the nonfacility different than for the global?
   (Please see the *Billed Together* tab in the RUC Database)

   Diagnostic Radiology is the dominant provider in both the non-facility and global settings.

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

Diagnostic Radiology performs the service 74.7% of the time in the non-facility.
Diagnostic Radiology performs the service 76.3% of the time for all sites (Global&26).

5. If you are requesting an increase over the aggregate current cost for clinical staff time, equipment, and supplies, please provide compelling evidence (please see *PE compelling evidence guidelines*) Please explain if the increase can be entirely accounted for because of an increase in physician time:

CPT code 76377 was last reviewed by the RUC in 2005. In the past 16 years, there have been significant changes in both technology and patient population, as well as changes in RUC methodology with standardization of times for practice expense inputs. These changes have resulted in increased times for this service. Specifically, the number and complexity of available post-processing software packages has increased since 2005, requiring more time to reconstruct and review images. Additionally, there has been a significant increase in patients eligible for nephron-sparing surgery for renal cell carcinoma since 2005. With modern treatment options, accurate and detailed 3D rendering is now a more significant component of surgical planning.

Specific PE inputs that have increased include:
CA013: The RUC standard is 2 minutes however we are requesting 1 minute. A separate workstation needs to be prepared, but this is less work than preparing the CT room equipment, so we reduced the standard and are requesting 1 minute for CA013.
CA014: The RUC standard is 1 minute. There is a separate order and protocol for this service, so it is not duplicative of work accounted for in the CT code.
CA030, CA031, CA032: These three clinical activities correspond to the old clinical activity *"Process films, hang films, and review study with interpreting MD prior to patient discharge."* Previously, 5 minutes were allotted for this clinical activity; however, we have updated our recommendations per new standards/baselines for the three clinical activities: We are recommending 3 minutes for CA030 (RUC standard for CT/MRI), 2 minutes for CA031 (RUC standard) and 1 minutes for CA032 (RUC standard), which totals 6 minutes.
ED053: The current inputs for this code does not include a professional PACS workstation. However, the work of this service includes dictating the report, which is done on a professional PACS workstation. Therefore, we are recommending 18 minutes based on the professional PACS formula.

CLINICAL STAFF ACTIVITIES

The RUC has agreed that there is a presumption of zero pre-service clinical staff time unless the specialty can provide evidence to the PE Subcommittee that any pre-service time is appropriate. The RUC agreed that with evidence some subset of codes may require minimal or extensive use of clinical staff and has allocated time when appropriate (for example when a service describes a major surgical procedure). If the package times are not applicable, alternate times may be presented and should be justified for consideration by the Subcommittee.

6. Are the global periods of the codes transitioning? Information about the amount of pre-service clinical staff time and a rationale for the change from a 090-day global to a 000 or 010 day global should be described below.

No.

7. If you are recommending more minutes than the PE Subcommittee standards for clinical activities, you must provide rationale to justify the time:

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

The specialties are proposing 3 minutes for CA030 – Technologist QC of images. The baseline is 2 minutes, but 3 minutes is the standard for procedures involving CT/MR.

8. If a clinical activity in your reference code(s) is being rolled into a similar clinical activity approved by the PE Subcommittee and assigned a clinical activity code (*please see second worksheet in PE spreadsheet workbook*), please explain the difference here:

The following April 2005 clinical activities for CPT code 76377 are being transitioned to these new clinical activity codes:

- The 33 minutes from "Assist physician in performing procedure/Computer post processing" (Old – April 2005) is being reassigned to CA021 "Perform procedure/service-NOT directly related to physician work time".
- The 5 minutes from "Process films, hang films, and review study with interpreting MD prior to patient discharge" (Old – April 2005) is being reassigned to "Technologist QC's images in PACS, checking for all images, reformats, and dose page" (CA030), "Review examination with interpreting MD/DO" (CA031), and "Scan exam documents into PACS. Complete exam in RIS system to populate images into work queue" (CA032). Per updated standards/baselines, this results in a total of 6 minutes for these clinical activities.

9. How much time was allocated to clinical activity, *obtain vital signs* (CA010) prior to CMS increasing the clinical activity to 5 minutes for calendar year 2018? The standard for clinical activity, obtains vital signs remains 0, 3 and 5 based on the number of vital signs taken. Please provide a rationale for the clinical staff time that you are requesting for obtain vital signs here:

N/A.

10. Please provide a brief description of the clinical staff work for the following:
    a. Pre-Service period:

N/A.

    b. Service period (includes pre, intra and post):

The technologist reviews the appropriateness of the request with the radiologist and obtains the source image files for 3D rendering on an independent workstation. The technologist prepares and manipulates the source images for 3D rendering and physician interpretation. The technologist reviews the examination with the interpreting physician as needed. The technologist transmits the 3D renderings into PACS, performs quality check of the images in PACS, and checks all images. The technologist completes the exam in the RIS system to populate images into the work queue.

    c. Post-service period:

N/A.

11. Please provide granular detail regarding what the clinical staff is doing during the intra-service (of service period) clinical activity, *assist physician or other qualified healthcare professional---directly related to physician work time* or *Perform procedure/service---NOT directly related to physician work time:*

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The technologist prepares and manipulates the source images for 3D rendering and physician interpretation. This service addresses complex renderings such as shaded surface rendering, volumetric rendering, maximum intensity projections, fusion of images from other modalities, and quantitative analysis (segmental volumes and surgical planning) that will best display the anatomy/pathology. The technologist then creates the appropriate 3D imaging dataset. This includes detailed manipulation of images in three dimensions to determine what anatomy to "cut out" and what to include. For example, in assessing a renal mass, the adjacent vasculature would be included but other anatomy which may or may not be in the same plane would be removed to optimally visualize vascular invasion or variant vascular anatomy in preparation for surgery. This process is labor intensive, requires special training, and may require several trial-and-error attempts to produce high quality 3D images. In addition to the renal cell carcinoma example in the vignette, this code is also used for tractography to generate white matter tracts in the brain to plan for surgery.

12. If you have used a percentage of the physician intra-service work time other then 100 or 67 percent for the intra-service (of service period) clinical activity, please indicate the percentage and explain why the alternate percentage is needed and how it was derived.
    N/A.

13. If you are recommending a new clinical activity, please provide a detailed explanation of why the new clinical activity is needed and cannot conform to any of the existing clinical activities (*please see second worksheet in PE spreadsheet*):
    N/A.

14. If you wish to identify a new staff type, please include a very specific staff description, salary estimate and its source. Staff types or an identified and appropriate proxy must be listed by the Bureau of Labor Statistics (BLS). You can find the BLS database at http://www.bls.gov.
    N/A.

MEDICAL SUPPLIES & EQUIPMENT/INVOICES

15. ☐ Please check the box to confirm that you have provided invoices for all new supplies and/or equipment?

16. ☐ Please check the box to confirm that you have provided an estimate price on the PE spreadsheet for all new supplies and/or equipment?

17. If you wish to include a supply that is not on the list (*please see fourth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the supply input and invoice here:
    N/A.

18. Are you recommending a PE supply pack for this recommendation? Yes or No.
    If Yes, please indicate if the pack is an established package of supplies as defined by CMS (eg, SA047 *pack, E/M visit*) or a pack that is commercially available?
    N/A.

19. Please provide an itemized list of the contents for all supply kits, packs and trays included in your recommendation. Please include the description, CMS supply code, unit, item quantity and unit price (if

available). See documents two and three under PE reference materials on the RUC Collaboration Website for information on the contents of kits, packs and trays.

N/A.

20. If you wish to include an equipment item that is not on the list (*please see fifth worksheet in PE spreadsheet*) please provide a paid invoice. Identify and explain the equipment input and invoice here:

N/A.

21. Please provide an estimate of the useful life of the new equipment item as required to calculate the equipment cost per minute (*please see fifth worksheet in PE spreadsheet*):

N/A.

22. Have you recommended equipment minutes for a computer or equivalent laptop/integrated computer, equipment item computer, desktop, w-monitor, ED021 or notebook (Dell Latitute D600), ED038?
    a. If yes, please explain how the computer is used for this service(s).
    b. Is the computer used exclusively as an integral component of the service or is it also used for other purposes not specific to the code?
    c. Does the computer include code specific software that is typically used to provide the service(s)?

N/A.

23. List all the equipment included in your recommendation and the equipment formula chosen *(*please see document titled *Calculating equipment time)*. If you have selected "other formula" for any of the equipment please explain here:

Computer Workstation, 3D Reconstruction CT-MR (ED014) – Highly Technical Formula
Professional PACS Workstation (ED053) – sum of ½ physician pre time + full physician intra time

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PRACTICE EXPENSE SUMMARY OF RECOMMENDATION (SOR)

PROFESSIONAL LIABILITY INSURANCE (PLI) INFORMATION

24. If this is a PE only code please select a crosswalk based on a similar specialty mix:

N/A.

ADDITIONAL INFORMATION

25. If there is any other item(s) on your spreadsheet not covered in the categories above that requires greater detail/explanation, please include here:

ITEMIZED LIST OF CHANGES (FOLLOWING THE PE SUBCOMMITTEE MEETING)

NOTE: The virtual meetings have provided for real-time updates to the PE spreadsheets. PE SORs must still be updated after the meeting and resubmitted asap.

During and immediately following the review of this tab at the PE Subcommittee meeting, please revise the summary of recommendation (PE SOR) based on modifications made during the meeting. Please submit the revised form electronically to Rebecca Gierhahn at rebecca.gierhahn@ama-assn.org immediately following the close of business. In addition, please also provide an itemized list of the modifications made to the PE spreadsheet during the PE Subcommittee meeting in the space below (e.g. clinical activity CA010 *obtain vital signs* was reduced from 5 minutes to 3 minutes).

	A	B	D	E	F	G	H	J
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**	**CURRENT**	**RECOMMENDED**
2						**76376**	**76377**	**76377**
3		***RUC Collaboration Website***				3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation **(April 2005)**	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation **(October 2021)**
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 17 Specialty: ACR, ASNR**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**			
5		**LOCATION**				**Non Fac**	**Non Fac**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**				**20.0**	**38.0**	**41.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L046A			**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L046A			**20.0**	**38.0**	**41.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L046A			**0.0**	**0.0**	**0.0**
12		**TOTAL COST OF CLINICAL STAFF TIME x RATE PER MINUTE**				**$ -**	**$ -**	**$ -**
13		**PRE-SERVICE PERIOD**						
14		**Start: Following visit when decision for surgery/procedure made**						
15	CA001							
16	CA002							
17	CA003							
18	CA004							
19	CA005							
20	CA006							
21	CA007							
22	CA008							
29		**End: When patient enters office/facility for surgery/procedure**						
30		**SERVICE PERIOD**						
31		**Start: When patient enters office/facility for surgery/procedure:**						
32		**Pre-Service (of service period)**						
33	CA009							
34	CA010							
35	CA011							
36	CA012							
37	CA013		L046A					**1**
38	CA014		L046A					**1**
39	CA015							
40	CA016							
41	CA017							
48		**Intra-service (of service period)**						
49	CA018							
50	CA019							
51	CA020							
52	CA021		L046A			**15**		**33**
53	*OLD*	Assist physician in performing procedure/Computer post processing	L046A				**33**	
59		**Post-Service (of service period)**						
60	CA022							
61	CA023							
62	CA024							
63	CA025							
64	CA026							
65	CA027							
66	CA028							
67	CA029							

	A	B	D	E	F	G	H	J
1	**RUC Practice Expense Spreadsheet**					**REFERENCE CODE**	**CURRENT**	**RECOMMENDED**
2						**76376**	**76377**	**76377**
3		***RUC Collaboration Website***				3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation (April 2018)	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation **(April 2005)**	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation **(October 2021)**
4	**Clinical Activity Code**	**Meeting Date: October 2021 Revision Date (if applicable): Tab: 17 Specialty: ACR, ASNR**	**Clinical Staff Type Code**	**Clinical Staff Type**	**Clinical Staff Type Rate Per Minute**			
5		**LOCATION**				**Non Fac**	**Non Fac**	**Non Fac**
6		**GLOBAL PERIOD**				**XXX**	**XXX**	**XXX**
7		**TOTAL COST OF CLINICAL ACTIVITY TIME, SUPPLIES AND EQUIPMENT TIME**				**$ -**	**$ -**	**$ -**
8		**TOTAL CLINICAL STAFF TIME**				**20.0**	**38.0**	**41.0**
9		**TOTAL PRE-SERVICE CLINICAL STAFF TIME**	L046A			**0.0**	**0.0**	**0.0**
10		**TOTAL SERVICE PERIOD CLINICAL STAFF TIME**	L046A			**20.0**	**38.0**	**41.0**
11		**TOTAL POST-SERVICE CLINICAL STAFF TIME**	L046A			**0.0**	**0.0**	**0.0**
68	CA030		L046A			**2**		**3**
69	CA031		L046A			**2**		**2**
70	CA032		L046A			**1**		**1**
71	CA033							
72	CA034							
73	CA035							
74	CA036						**n/a**	**n/a**
75	*OLD*	Process films, hang films and review study with interpreting MD prior to patient discharge	L046A				**5**	
81		**End: Patient leaves office/facility**						
82		**POST-SERVICE PERIOD**						
83		**Start: Patient leaves office/facility**						
99		**End: with last office visit before end of global period**						
100	**Supply**	**MEDICAL SUPPLIES**	**PRICE**	**UNIT**				
110	**Equipment Code**	**EQUIPMENT**	**Purchase Price**	**Equipment Formula**	**Cost Per Minute**			
111		**TOTAL COST OF EQUIPMENT TIME x COST PER MINUTE**				**$ -**	**$ -**	**$ -**
112	ED014			Default			**38**	**35**
113	ED050			PACS		**20**		
114	ED053			Other Formula		**12**		**18**