AMA/Specialty Society RVS Update Committee
Meeting Minutes
October 1-3, 2015

I. Welcome and Call to Order

Doctor Peter Smith called the meeting to order on Thursday, October 1, 2015 at 1:00 pm. The following RUC Members were in attendance:

Peter K. Smith, MD
Margie C. Andreae, MD
Michael D. Bishop, MD
James Blankenship, MD
Dale Blasier, MD
Albert Bothe, MD
Ronald Burd, MD
Scott Collins, MD
Thomas Cooper, MD
Jane Dillon, MD
Verdi. J DiSesa, MD
James Gajewski, MD
David F. Hitzeman, DO
Robert Kossmann, MD
Walt Larimore, MD
Alan Lazaroff, MD
J. Leonard Lichtenfeld, MD
Scott Manaker, MD, PhD
Geraldine B. McGinty, MD
Margaret Neal, MD
Guy Orangio, MD
Gregory Przybylski, MD
Marc Raphaelson, MD
Sandra Reed, MD
Joseph Schlecht, DO
Stanley W. Stead, MD, MBA
James C. Waldorf, MD
Jane White, PhD, RD, FADA, LDN
Jennifer L. Wiler, MD
George Williams, MD

Amr Abouleish, MD, MBA*
Allan A. Anderson, MD*
Jennifer Aloff, MD*
Gregory L. Barkley, MD*
Eileen Brewer, MD*
Jimmy Clark, MD*
Joseph Cleveland, MD*
Gregory DeMeo, MD*
William D. Donovan, MD, MPH, FACR*
Jeffrey Paul Edelstein, MD*
Michael J. Gerardi, MD, FACEP*
Peter Hollmann, MD*
John Lanza, MD*
M. Douglas Leahy, MD, MACP*
Mollie MacCormack, MD*
Paul Martin, DO, FACOFP*
Daniel J. Nagle, MD*
Scott D. Oates, MD*
Christopher K. Senkowski, MD, FACS*
M. Eugene Sherman, MD*
Samuel Silver, MD*
Norman Smith, MD*
Holly Stanley, MD*
Robert J. Stomel, DO*
G. Edward Vates, MD*
Adam Weinstein, MD*

*Alternate

II. Chair's Report

- Doctor Smith welcomed everyone to the RUC Meeting.
- Doctor Smith welcomed the following Centers for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting:
    - Edith Hambrick, MD - CMS Medical Officer
    - Karen Nakano, MD - CMS Medical Officer
    - Steve Phurrough, MD - CMS Medical Officer
    - Marge Watchorn - Deputy Director, Division of Practitioner Services

- Doctor Smith welcomed the following Contractor Medical Directors:
    - Charles Haley, MD, MS, FACP
- Doctor Smith welcomed the following Members of the CPT Editorial Panel:
    - Antonio Puente, PhD – Panel Member Observer
    - Kathy Krol, MD – Panel Member Observer
- Doctor Smith and the RUC said farewell to departing RUC members:
    - Leonard Lichtenfeld, MD
    - Sandra Reed, MD
- Doctor Smith welcomed new RUC members:
    - Michael D. Bishop, MD
    - Jane Dillon, MD, MBA, FACS
    - Verdi J. DiSesa, MD, MBA
    - James L. Gajewski, MD, FACP
    - Guy R. Orangio, MD, FACS, FASCRS
    - Jane V. White, PhD, RD, FADA, LDN
    - Jennifer L. Wiler, MD, MBA
- Doctor Smith welcomed new RUC alternate members:
    - Joseph C. Cleveland, Jr, MD
    - Michael J. Gerardi, MD, FAAP, FACEP
    - Peter A. Hollmann, MD
    - John T. Lanza, MD, FACS
    - Dee Adams Nikjeh, PhD, CCC-SLP
    - Samuel Silver, MD
- Doctor Smith assured those present that the RUC is having an impact and with the help of this very capable body the RUC will continue to make an impact into the future. Doctor Smith also commented that specialties often feel that they have a target on them, but it is important that all specialties work collaboratively to have the greatest impact.
- Doctor Smith explained the following RUC established thresholds for the number of survey responses required:
    - Codes with ≥1 million Medicare Claims = **75 respondents**
    - Codes with Medicare Claims from 100,000 to 999,999 = **50 respondents**
    - Codes with <100,000 Medicare = **30 respondents**
    - Surveys below the established thresholds for services with Medicare claims of 100,000 or greater will be reviewed as interim and specialty societies will need to resurvey for the next meeting.
- Doctor Smith laid out the following guidelines related to confidentiality:
    - All RUC attendees/participants are obligated to adhere to the RUC confidentiality policy. (All signed an agreement at the registration desk)
    - This confidentiality is critical because CPT® codes and our deliberations are preliminary. It is irresponsible to share this information with media and others until CMS has formally announced their decisions in rulemaking.
- Doctor Smith shared the following procedural rules for RUC members:
    - Before a presentation, any RUC member with a conflict will state their conflict. That RUC member will not discuss or vote on the issue and it will be reflected in the minutes
    - RUC members or alternates sitting at the table may not present or debate for their society
    - Expert Panel – RUC Members exercise their independent judgment and are not advocates for their specialty

- Doctor Smith laid out the following procedural guidelines related to commenting specialty societies:
    - In October 2013, the RUC implemented that the metric to determine who may be "conflicted" to speak to an issue before the RUC be:
        - If a specialty surveyed (LOI=1) or
        - submitted written comments (LOI=2)
        - RUC members from these specialties are not assigned to review those tabs.
    - The RUC also recommended that the RUC Chair invite the RUC Advisor for any specialty society that submitted written comments (LOI=2), to come to the table to verbally address these written comments. It is the discretion of that society if they wish to sit at the table and provide further verbal comments.
- Doctor Smith shared the following guidelines related to voting:
    - RUC votes are published annually on the AMA RBRVS web site each November for the previous CPT cycle.
    - The RUC votes on every work RVU, including facilitation reports
    - Please share voting remotes with your alternate if you step away from the table
    - To insure we have 28 votes, may necessitate re-voting throughout the meeting
    - If members are going to abstain from voting or leave the table please notify AMA staff so we may account for all 28 votes
- Doctor Smith announced:
    - That all meetings are recorded for AMA staff to accurately summarize recommendations to CMS.
    - Only use Wi-Fi when necessary and limit to one device so they do not interrupt the work of the RUC.
- September 24th Meeting with Sean Cavanaugh:
    - Introductory meeting with new CPT Editorial Panel and RUC Chairs
    - Discussed payment for care collaboration and care management – current CPT codes that have RUC values and have not previously been paid by Medicare.
    - Discussed need for transparency in decision making on moderate sedation services.
    - Discussed need to work together for new coding initiatives requested by CMS.
- Visitor Observation at the RUC
    - Dr. Armando Lara-Millan has proposed a scientific publication related to his observations of the RUC process.
    - All observations de-identified, publication to be reviewed by AMA
    - Publication to be delayed by 1 year, so that code values will be finalized
    - Individual interviews will be accompanied by individual consent, and will of course be voluntary
    - Contingent upon obtaining "waiver of consent" from his IRB
    - January meeting anticipated
- As many of you know, RUC members Chad Rubin, MD is seriously ill with stage 4 lung cancer. He is doing very well and the chemotherapy is working. The RUC has sent him a care package with chicken noodle soup, rolls and cookies. Doctor Rubin promises to be at the January RUC meeting. We are all looking forward to seeing him then.
- Please check the documents regarding the new Subcommittee and Workgroups and the members of those groups.

III. Director's Report

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

- Reviewed the implications on the timeline for the January RUC meeting that result from moving CMS deadline for RUC recommendations back to February 10th. This means that the review of the RUC agenda will be over the holidays.
- CPT is working hard to turn around the LOI, so that surveys can be ready to go two weeks from now.
- Agenda materials will be available December 16th.
- RUC members will have until January 4th to review and reply with comments. This is a longer period of time, but it will be over the holidays.
- Handouts are usually available about a week before the meeting, however for January handouts will not be available until a few days before the meeting.

IV. Approval of Minutes of the April 22-25, 2015 RUC Meeting

The RUC approved the April 2015 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update (Informational)

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

- The CPT Editorial Panel met in San Francisco in May and Doctor Blasier attended as a representative of the RUC.
- Tab three contains the usual update of coding changes that have been approved and are in process for 2017. It also contains status reports on CMS requests and RAW referrals as well as the status of yet to be completed action plans.
- CPT has again updated the coding proposal application form. It will be in effect for the November deadline. It clarifies for the proposer, the relationship of category I and III codes to the literature requirements. In addition, it strengthens the requirement for English language literature and outlines the maximum set of articles related to any individual event.

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

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

- Doctor Smith already introduced the new members of our department.
- CMS is currently in the comment period. We are somewhat limited in the responses we can give, but will try to be as responsive as possible.
- The final rule will be available on or about November 1.

VII. Contractor Medical Director Update (Informational)

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

- ICD-10 went into effect yesterday. The code set is effective for any physician claim that has a “from” date of October 1st or later or a hospital discharge date of October 1st or later. There are very few claims so far. CMS is currently having daily calls with contractors to monitor the situation. We are looking at the number of claims received, number of claims rejected by

the front end EDI system, number of claims suspended, number of claims reopened and call center volume. We know of no problems so far, but it is still very early.

- Two of the durable medical equipment MAC contracts were awarded in the last month:
  - Jurisdiction B, the Midwestern states, was awarded to CGS. The incumbent was NGS and they have filed a protest.
  - Jurisdiction D, the Western states, was awarded to Noridian. Noridian is the incumbent and there has been no protest as of today.
- One A/B MAC contract was awarded since the last RUC meeting:
  - Jurisdiction 15, Ohio and Kentucky, was awarded to CGS. CGS is the incumbent and there has been no protest.
- For the last two years the A/B MAC contractors have been doing medical reviews for the two midnight rule that CMS rolled out two years ago to clarify the boundary between Medicare part A and part B for a hospital stay. As of yesterday, this work will be transitioned to the Quality Improvement Organizations (QIOs). If the QIOs find a hospital that is not compliant they are instructed to turn that hospital over to the recovery auditors.

IX. Relative Value Recommendations for *CPT 2016*:

<u>Percutaneous Biliary Procedures Bundling (Tab 4)</u>
Jerry Niedzwiecki, MD (SIR); Michael Hall, MD (SIR); Bob Vogelzang, MD (SIR); Tim Swan, MD (SIR); Matt Hawkins, MD (SIR); Zeke Silva, MD (ACR); and Kurt Schoppe, MD (ACR)

Facilitation Committee #1

The Joint CPT-RUC Workgroup on codes reported together frequently identified codes that are being reported together greater than 75 percent of the time and as a result the CPT Editorial Panel deleted codes 47500, 47505, 47510, 47511, 47525, 47530, 74305, 74320, 74327, 79580 and 75982 and created 14 new bundled codes 47531-47544. At the April 2015 RUC meeting, the RUC and specialty societies agreed that the survey data for this family of services was problematic. Specifically, the RUC noted the median intra-service times for 47532, 47533 and 47534 all have identical intra-service time of 60 minutes, which made it difficult to properly interpret the survey data. CPT code 47533 includes the work of 47532 plus the work of an additional access and drain placement. Furthermore, CPT code 47534 includes the work of 47533 plus the work of crossing the occlusion and placement of an internal/external drain. Given this physician time anomaly, the RUC agreed to provide interim recommendations at the April 2015 meeting, while allowing the specialty societies to re-survey the entire family of codes for October 2015.

<u>Compelling Evidence</u>
The specialty societies presented compelling evidence that the physician work involved in these procedures has changed.

<u>Technique, Knowledge and Technology</u>
The codes currently used for this family of biliary procedures no longer reflect the techniques now used for image-guided, catheter-based biliary procedures. Virtually all the medical devices currently used in biliary catheter procedures have been developed since the current codes were adopted. The past twenty years have witnessed major advances in the knowledge base, including: 1) understanding of how to use imaging guidance such as ultrasound and preoperative planning mapping to avoid hepatic hilar structures and thus prevent bleeding and bile leaks; 2) new insights into how segmental biliary ductal anatomy can help avoid bleeding

and septic complications and 3) development of much less aggressive and safer guidewire-based methods which involve more steps and more effort, skill and physician time.

Patient Population
There are three changes to the patient population which have occurred since the last valuation of the current procedures, including: 1) previously the majority of all biliary catheter procedures were used for basic relief of distal ductal biliary obstruction either acutely or chronically often related to pancreatic cancer and/or stone disease. The significant majority of all of the biliary diseases referred for interventional percutaneous treatment now have higher and more complex levels of benign and malignant biliary occlusion including hilar and segmental obstruction; 2) the widespread use of liver transplantation has introduced an entirely different patient population: the postoperative liver transplant patient with ischemic biliary strictures (intrahepatic and/or extrahepatic), which requires major investments of time, skill and effort to obtain access and drain, stent and dilate these complex situations and 3) hepatic surgery for malignancy has also become far more sophisticated and segmental or lobar resections will frequently result in referrals for drainage of biliary leaks from non-dilated ducts.

Given these changes, the RUC accepted that there is compelling evidence that the physician work has change for this family of services.

47531 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 27 minutes, intra-service time of 15 minutes and immediate post-service time of 12 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and determined that due to the lower total time in survey data compared with the existing codes total time in the RUC database, the values are overestimated at the 25th percentile work RVU of 1.50. To determine an appropriate work value, the RUC compared 47531 to CPT code 46611 *Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique* (work RVU= 1.30, intra time= 15 minutes) and noted that both services have identical intra-service time and offered a reasonable physician work comparison to the surveyed code. Therefore, the RUC agreed that a direct work value crosswalk to 46611 is appropriate. To validate a work RVU of 1.30, the committee also reviewed code 36580 *Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access* (work RVU= 1.31, intra time= 15 minutes) and noted the identical intra-service times and comparable physician work between the two services. **The RUC recommends a work RVU of 1.30 for CPT code 47531.**

47532 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access (eg, percutaneous transhepatic cholangiogram)
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this

procedure: pre-service time of 38 minutes, intra-service time of 45 minutes and immediate post-service time of 15 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and agree that the survey 25th percentile work value of 4.50 is appropriate for this procedure. To justify a work value of 4.50, the RUC compared the surveyed code to the top key reference code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50, intra time= 45 minutes) and agreed that since both services have identical intra-service time and comparable physician work, the work value of both codes should be the same. The RUC also reviewed reference code 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50, intra time= 45 minutes) and noted that with identical intra-service time, the two services should be valued identically. **The RUC recommends a work RVU of 4.50 for CPT code 47532.**

47533 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; external
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 60 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work value of 5.63 is appropriate. To justify a work RVU of 5.63, the RUC compared the surveyed code to reference codes 32601 *Thoracoscopy, diagnostic (separate procedure); lungs, pericardial sac, mediastinal or pleural space, without* biopsy (work RVU= 5.50, intra time= 60 minutes) and code 32998 *Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral* (work RVU= 5.68, intra time= 60 minutes) and agreed that with identical intra-service times, these reference codes offer appropriate brackets around the recommended work value for 47533. **The RUC recommends a work RVU of 5.63 for CPT code 47533.**

47534 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; internal-external
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 68 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the 25th percentile work RVU of 7.85 is appropriate for this procedure. To justify a work RVU of 7.85 for CPT code 47534, the RUC compared the surveyed code to the second highest key reference code 37211 *Transcatheter therapy, arterial infusion for thrombolysis other than coronary, any method, including radiological supervision and interpretation, initial treatment day* (work RVU= 8.00, intra time= 60 minutes) and agreed that since the reference code has slightly greater total time than 47534, 138 minutes and 129 minutes, respectively, it is appropriately valued higher. The RUC also reviewed MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU= 7.50, intra time= 60 minutes) and noted similar intra-service times and comparable physician work to 47534. **The RUC recommends a work RVU of 7.85 for CPT code 47534.**

47535 Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation

The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 33 minutes, intra-service time of 45 minutes and immediate post-service time of 15 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work value of 4.20 is appropriate. To justify a work RVU of 4.20, the RUC compared the surveyed code to the top key reference code 36247 *Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family* (work RVU= 6.29, intra time= 60 minutes) and agreed that with 15 additional minutes of intra-service time, the reference code is appropriately valued higher. The RUC also reviewed codes 31634 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with balloon occlusion, with assessment of air leak, with administration of occlusive substance (eg, fibrin glue), if performed* (work RVU= 4.00, intra time= 45 minutes) and 49407 *Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, transvaginal or transrectal* (work RVU= 4.50, intra time= 45 minutes) and agreed that both these comparable services offer appropriate brackets above and below the recommended value for the surveyed code. **The RUC recommends a work RVU of 4.20 for CPT code 47535.**

47536 Exchange of biliary drainage catheter (eg. external, internal-external , or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation

The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 28 minutes, intra-service time of 20 minutes and immediate post-service time of 13 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work value of 2.86 is appropriate. To justify a work RVU of 2.86, the RUC compared the surveyed code to the top key reference service 49452 *Replacement of gastro-jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report* (work RVU= 2.86, intra time= 20 minutes) and agreed that both services have identical intra-service time and should be valued identically. The RUC also reviewed the MPC code 31622 *Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; diagnostic, with cell washing, when performed (separate procedure)* (work RVU= 2.78, intra time= 30 minutes) and noted that while the reference code has more intra-service time than 47536, both services have nearly identical total time. Therefore, the surveyed code is appropriately valued slightly higher than this MPC code. **The RUC recommends a work RVU of 2.86 for CPT code 47536.**

47537 Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 27 minutes, intra-service time of 15 minutes and immediate post-service time of 10 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work value of 1.84 is appropriate. To justify a work RVU of 1.84, the RUC compared the surveyed code to the top key reference service 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (work RVU= 2.00, intra time= 25 minutes) and noted that since this reference code has more intra-service time than 47537, it is appropriately valued higher. The RUC reviewed reference code 45309 *Proctosigmoidoscopy, rigid; with removal of single tumor, polyp, or other lesion by snare technique* (work RVU= 1.50, intra time= 15 minutes) and MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU= 1.90, intra time= 15 minutes) and noted that both these services, with identical intra-service time, offer appropriate brackets above and below the recommended value. **The RUC recommends a work RVU of 1.84 for CPT code 47537.**

47538 Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange or removal when performed, and all associated radiological supervision and interpretation, each stent; existing access
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 38 minutes, intra-service time of 53 minutes and immediate post-service time of 15 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work value of 5.00 is appropriate. To justify a work RVU of 5.00, the RUC compared the surveyed code to CPT codes 43242 *Esophagogastroduodenoscopy,*

flexible, transoral; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum or a surgically altered stomach where the jejunum is examined distal to the anastomosis) (work RVU= 4.83, intra time= 50 minutes) and 50384 *Removal (via snare/capture) of internally dwelling ureteral stent via percutaneous approach, including radiological supervision and interpretation* (work RVU= 5.00, intra time= 55 minutes) and agreed that since both these services have similar intra-service time and comparable physician work, the recommended value appropriately aligns with these services. **The RUC recommends a work RVU of 5.00 for CPT code 47538.**

47539 Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange or removal when performed, and all associated radiological supervision and interpretation, each stent; new access, without placement of separate biliary drainage catheter
The RUC reviewed the survey results from 41 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 75 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work value of 9.00 is appropriate. To justify a work RVU of 9.00, the RUC compared the surveyed code to the top key reference service 37226 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 10.49, intra time= 90 minutes) and noted that since the reference code has more intra-service time, it is appropriately valued higher. The RUC also reviewed code 37224 *Revascularization, endovascular, open or percutaneous, femoral, popliteal artery(s), unilateral; with transluminal angioplasty* (work RVU= 9.00, intra time= 80 minutes) and agreed that this comparable service, with similar time components, should be valued identically to the surveyed code. **The RUC recommends a work RVU of 9.00 for CPT code 47539.**

47540 Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange or removal when performed, and all associated radiological supervision and interpretation, each stent; new access, with placement of separate biliary drainage catheter (eg, external or internal-external)
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 85 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work value of 9.28 is appropriate. To justify a work RVU of 9.28, the RUC compared the surveyed code to the second highest key reference service 37228 *Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral,*

initial vessel; with transluminal angioplasty (work RVU= 11.00, intra time= 90 minutes) and agreed that since this code has more total time than 47540, 168 minutes compared to 146 minutes, it is appropriately valued higher than the recommended value. The RUC also reviewed codes 52355 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with resection of ureteral or renal pelvic* tumor (work RVU= 9.00, intra time= 90 minutes) and 37221 *Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed* (work RVU= 10.00, intra time= 90 minutes) and agreed that with similar time components and comparable physician work, these two codes provide appropriate brackets above and below the recommended value. **The RUC recommends a work RVU of 9.28 for CPT code.**

47541 Placement of access through the biliary tree and into small bowel to assist with an endoscopic biliary procedure (eg, rendezvous procedure), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; new access
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that the following physician times accurately account for the work of this procedure: pre-service time of 41 minutes, intra-service time of 60 minutes and immediate post-service time of 20 minutes. The RUC agreed to add two additional positioning minutes to account for positioning the patient on the angiographic table, as well as optimize patient protective lead apron placement to avoid obscuring the operative field.

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work value of 7.00 is appropriate. To justify a work RVU of 7.00, the RUC compared the surveyed code to MPC code 52353 *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included)* (work RVU= 7.50, intra time= 60 minutes) and agreed that since both these procedures have identical intra-service time, they should be valued similarly. The RUC also reviewed CPT codes 32608 *Thoracoscopy; with diagnostic biopsy(ies) of lung nodule(s) or mass(es) (eg, wedge, incisional), unilateral* (work RVU= 6.84, intra time= 60 minutes) and 37212 *Transcatheter therapy, venous infusion for thrombolysis, any method, including radiological supervision and interpretation, initial treatment day* (work RVU= 7.06, intra time= 60 minutes) and agreed that these codes, with similar time components, offer appropriate brackets above and below the recommended value. **The RUC recommends a work RVU of 7.00 for CPT code 47541.**

47542 Balloon dilation of biliary duct(s) or of ampulla (sphincteroplasty), percutaneous, including imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation, each duct (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that an intra-service time of 30 minutes for this add-on procedure is appropriate. To determine an appropriate work value for 47542, the RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work RVU of 2.85 is appropriate. To justify this work value, the RUC compared the surveyed code to the top reference service 37222 *Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty* (work RVU= 3.73, intra time= 40 minutes) and agreed that with 10 additional minutes above 47542, the reference code is appropriately valued higher. The RUC also reviewed CPT codes 36476 *Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins*

treated in a single extremity, each through separate access sites (work RVU= 2.65, intra time= 30 minutes) and 32507 *Thoracotomy; with diagnostic wedge resection followed by anatomic lung* resection (work RVU= 3.00, intra time= 30 minutes) and agreed that these services, with identical time, represent appropriate brackets above and below the recommended value. **The RUC recommends a work RVU of 2.85 for CPT code 47542.**

47543 Endoluminal biopsy(ies) of biliary tree, percutaneous, any method(s) (eg, brush, forceps and/or needle), including imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation, single or multiple (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 42 interventional radiologists and agreed with the specialty societies that an intra-service time of 30 minutes for this add-on procedure is appropriate. To determine an appropriate work value for 47543, the RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 3.00 is appropriate. To justify this work value, the RUC compared the surveyed code to the top key reference code 37185 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family* (work RVU= 3.28, intra time= 40 minutes) agreed that the reference code, with 10 additional minutes of intra-service time, should be valued higher than 47543. The RUC also reviewed codes 37239 *Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein* (work RVU= 2.97, intra time= 30 minutes) and 32668 *Thoracoscopy, surgical; with diagnostic wedge resection followed by anatomic lung resection* (work RVU= 3.00, intra time= 30 minutes) and agreed that these services, with identical time, represent appropriate brackets above and below the recommended value. **The RUC recommends a work RVU of 3.00 for CPT code 47543.**

47544 Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous, including destruction of calculi by any method (eg, mechanical, electrohydraulic, lithotripsy) when performed, imaging guidance (eg, fluoroscopy) and all associated radiological supervision and interpretation (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 32 interventional radiologists and agreed with the specialty societies that an intra-service time of 45 minutes for this add-on procedure is appropriate. To determine an appropriate work value, the RUC reviewed the survey respondents' reported physician work values and determined that they appeared overestimated at the 25th percentile (work RVUs= 3.95). Given this, the RUC considered two CPT codes 37185 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family* (work RVU= 3.28, intra time= 40 minutes) and 92973 *Percutaneous transluminal coronary thrombectomy mechanical* (work RVU= 3.28, intra time= 40 minutes) and agreed that both these services have analogous work to the surveyed code and should be valued identically. Therefore, the RUC recommends a direct work value crosswalk from these two reference codes to 47544. **The RUC recommends a work RVU of 3.28 for CPT code 47544.**

Practice Expense

The RUC reviewed and approved the direct practice expense inputs with the following revisions as approved by the PE Subcommittee:

- The PE Subcommittee had extensive discussion regarding the pre-service time for these services, reminding the specialty that zero minutes of clinical staff time is standard for 000 and 010 day globals. The PE Subcommittee determined that the standard for extensive use of clinical staff time in the facility setting, of 30 minutes is not appropriate. However, the services do require more pre-service time than the standard for minimal use of clinical staff time in the facility setting of 15 minutes. The PE Subcommittee determined that 19 minutes of pre-service time in the facility setting is appropriate for the services in the family that are done in the facility outpatient setting, similar to recently reviewed gastroenterology procedures, and for example esophagoscopy services (CPT codes 43211, 43213, 43214, 43212, 43229). There was additional discussion about clinical staff coming from the physician's office to the facility to consent the patient. The PE Subcommittee agreed that the time would be duplicative of the duties of the clinical staff in the facility. The specialty proposed and the PE Subcommittee agreed that services performed in the inpatient facility setting should have 14 minutes of pre-service time because the 5 minutes to provide pre-service education/obtain consent should be removed.
- Many of the interventional radiology services include three staff to assist the physicians in performing the procedure during the intra-service portion of the service period. Generally an RN assists with the moderate sedation, another staff assists the physician in performing the procedure and a third staff (two staff types, but equal to one staff) acquires the images and circulates (RT acquire images 75% of intra-service time and RN/LPN/MTA circulates 25% of intra-service time). For CPT codes 47531 and 47537 moderate sedation is not administered, however the specialty society recommended and the PE subcommittee agreed that three staff remain actively engaged in the procedure and necessary to assist the physician in performing the procedure; acquire images and circulate; as well as monitor the patient. Additionally, the PE Subcommittee recommends 4 hours of monitoring time (15 minutes of RN clinical staff time related to moderate sedation and 45 minutes not related to moderate sedation) for codes that include moderate sedation, and 1 hour (15 minutes of RN/LPN/MTA clinical staff time not related to moderate sedation) for 47531 and 47537 which do not include moderate sedation. The moderate sedation monitoring equipment is used for all the monitoring time, both following moderate sedation and following the procedure.
- The PE Subcommittee recommends 6 minutes of clinical staff time to clean room/equipment rather than the standard 3 minutes due to the bodily fluids involved and the large amount of equipment.
- The specialty societies clarified that there are no balloon dilation catheters specifically for the biliary tree. The supply item, catheter, balloon, PTA (SD152) used in some of these services is not only an angioplasty balloon; it is appropriately used in these services as a dilation device. The supply item, tray, shave prep (SA067) is used to prepare the area and is needed for all the services except for 47531 and 47537.
  The supply item, pack, cleaning and disinfecting, endoscope (SA042) which was used a proxy for the necessary cleaning supplies for the room was removed and replaced with 1 supply item, gloves, non-sterile (SB022) and 3 supply items, sanitizing cloth-wipe (surface, instruments, equipment) (SM022), the correct supplies necessary to clean the room for these services.

Intracranial Endovascular Intervention (Tab 5)

Alexander Mason, MD (CNS); John Ratliff, MD (AANS); Henry Woo, MD (CNS); Jerry Niedzwiecki, MD (SIR); Michael Hall, MD (SIR); Joshua A. Hirsch, MD (ASNR); Gregory N. Nicola, MD (ASNR); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR)

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

CPT codes 75896 and 75898 were also identified as part of this family of services. The specialty societies requested to refer these services to the CPT Editorial Panel as a coding change proposal was submitted for review at the May 2015 CPT meeting to delete code 75896 and a multispecialty coding change proposal is scheduled to be addressed in a future CPT cycle. The new codes approved for intracranial thrombolysis and intracranial mechanical thrombectomy are expected to be utilized instead of 75898. The work remaining in 75798 will be appropriately surveyed by physicians who perform such work. The RUC is scheduled to review the utilization of 75898 at the October 2016 Relativity Assessment Workgroup meeting.

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

<u>Reflectance Confocal Microscopy (Tab 6)</u>
Mark Kaufmann, MD (AAD); Harold Rabinovitz, MD(AAD); Jane Grant-Kels, MD (AAD)

In February 2015, the CPT Editorial panel established six new Category I codes to describe reflectance confocal microscopy (RCM) for imaging of skin.

At the April 2015 RUC meeting, following the RUC's review and acceptance of physician work and direct practice expense, new information was brought to the attention of the RUC which called into question how much physician work and clinical labor are typically part of these six services. The identified source, the vendor's SEC 10-K Annual Report for the period ending 12/31/2013, included information which alluded to the physician work and clinical labor of a similar procedure possibly taking different time than the estimates

originally presented to the RUC. Furthermore, it was also called into question if there were other devices used to perform this service that the RUC was unaware of at the April 2015 RUC meeting and that may necessitate a revised coding structure. The presenters who would have been able to offer an informed opinion on this document were no longer at the meeting when the issue was raised. Therefore, at the time, the RUC requested that the specialty re-survey this family of services and resubmit physician work and direct practice expense recommendations for the October 2015 RUC meeting.

The American Academy of Dermatology Association (AADA) appealed the RUC's recommendation to contractor-price these services and re-survey for October 2015. AADA requested that the RUC reconsider its previous recommendation to resurvey these services for October 2015, but to present the valid survey data from April 2015.

The RUC organized an Ad Hoc Appeals Committee to review the appeal and make a recommendation. The Appeals Committee noted the concerns about using these codes to report RCM using a handheld device and agreed with the specialty society to submit a parenthetical request to the CPT Editorial Panel to prevent this use as well as develop an education CPT Assistant article. The Appeals Committee noted that the RUC's primary concern in April was regarding defining the physician work versus clinical staff work for image acquisition and physician time to perform image review and interpretation. The Committee noted that another targeted survey, most likely to the same individuals, would not produce significantly different results. Therefore, it is appropriate that the specialty society present the survey data from April 2015.

On June 11 2015, the Ad Hoc Appeals Committee recommended for the RUC to reconsider its April 2015 recommendation for Reflectance Confocal Microscopy (RCM) codes 96931-96936 and that the RUC consider the AADA request to return to the October 2015 RUC meeting, present the April 2015 survey data with additional information in response to the SEC 10-K report and the RUC to make work and practice expense recommendations. The Ad Hoc Appeals Committee also supported the specialty society's submission to the CPT Editorial Panel to create parentheticals and a CPT Assistant article to foster correct reporting of these services.
At the October 2015 CPT Editorial Panel meeting, the Panel approved the following CPT Introductory Guideline to prevent the use of 96931-96936 with the screening handheld device:

Codes 96931-96936 describe the acquisition and/or diagnostic interpretation of the device generated stitched image mosaics related to a single lesion. Do not report 96931-96936 for a reflectance confocal microscopy examination that does not produce mosaic images. For services rendered using reflectance confocal microscopy not generating mosaic images, use 96999.

96931 ***Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, first lesion***
The RUC reviewed the survey results from 38 dermatologists and dermatopathologists and agreed with the following physician time components: pre-service time of 3 minutes, intra-service time of 25 minutes, and post-service time of 0 minutes.

The specialty society noted when a dermatologist identifies a lesion of concern, in lieu of biopsying the lesion, the dermatologist may order a reflectance confocal microscopy study. The image acquisition entails a nurse or technologist acquiring a series of 0.5mm by 0.5mm

images then the machine's software stitches those images together to form a mosaic image so a lesion of up to 8mm in diameter can be reviewed. Several layers of the skin are imaged in this fashion and reviewed by the dermatopathologist or pathologist, including: the stratum corneum, the stratum granulosum, the stratum spinosum, the epidermal interface and the superficial dermis. Reading these images requires a great deal of skill to interpret.

To determine an appropriate work value for 96931, the RUC reviewed the survey respondents' estimated physician work value and agreed the respondents overestimated the physician work with the 25th percentile work RVU of 0.90. The specialty society noted and the RUC agreed that the physician work for 96931 and 96933 are identical and therefore should be valued the same. Therefore, the RUC also reviewed the 25th percentile work RVU of 0.80 from survey code 96933 and agreed that this value appropriately accounts for the physician work involved for both 96931 and 96933. To justify a work RVU of 0.80, the RUC reviewed top key reference code 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU=0.75, intra-service time of 25 minutes) and noted both services have identical intra-service time, whereas the survey code has more total time (28 minutes vs 25 minutes), justifying a somewhat higher work value for 96931. To further support a work RVU of 0.80, the RUC reviewed CPT code 43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)* (work RVU= 0.81, intra-service time of 20 minutes and total time of 30 minutes) and noted that both codes have similar intensities, while the survey code has more intra-service time and the reference code has more total time. The RUC agreed that both services should be valued similarly. **The RUC recommends a work RVU of 0.80 for CPT code 96931.**

96933 *Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report, first lesion*
The RUC reviewed the survey results from 38 dermatologists and dermatopathologists and agreed with the following physician time components: pre-service time of 3 minutes, intra-service time of 25 minutes, and post-service time of 0 minutes.

The specialty society noted when a dermatologist identifies a lesion of concern, in lieu of biopsying the lesion, the dermatologist may order a reflectance confocal microscopy study. The image acquisition entails a nurse or technologist acquiring a series of 0.5mm by 0.5mm images then the machine's software stitches those images together to form a mosaic image so a lesion of up to 8mm in diameter can be reviewed. Several layers of the skin are imaged in this fashion and reviewed by the dermatopathologist or pathologist, including: the stratum corneum, the stratum granulosum, the stratum spinosum, the epidermal interface and the superficial dermis. Reading these images requires a great deal of skill to interpret.

To determine an appropriate work value for 96933, the RUC reviewed the survey respondents' 25th percentile work value of 0.80 and agreed this value appropriately accounts for the physician work involved. The specialty society noted and the RUC agreed that the physician work for 96931 and 96933 are identical and therefore should be valued the same. To justify a work RVU of 0.80, the RUC reviewed top key reference code 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU=0.75, intra-service time of 25 minutes) and noted both services have identical intra-service time, whereas the survey code has more total time (28 minutes vs 25 minutes), justifying a somewhat higher work value for 96931. To further support a work RVU of 0.80, the RUC reviewed CPT code 43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)* (work RVU= 0.81, intra-service

time of 20 minutes and total time of 30 minutes) and noted that both codes have similar intensities, while the survey code has more intra-service time and the reference code has more total time. The RUC agreed that both services should be valued similarly. **The RUC recommends a work RVU of 0.80 for CPT code 96933.**

96934 ***Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; image acquisition and interpretation and report, each additional lesion (List separately in addition to primary procedure)***

The RUC reviewed the survey results from 36 dermatologists and dermatopathologists and agreed with the following physician time components: pre-service time of 0 minutes, intra-service time of 25 minutes, and post-service time of 0 minutes.

The specialty society noted when a dermatologist identifies a lesion of concern, in lieu of biopsying the lesion, the dermatologist may order a reflectance confocal microscopy study. The image acquisition entails a nurse or technologist acquiring a series of 0.5mm by 0.5mm images then the machine's software stitches those images together to form a mosaic image so a lesion of up to 8mm in diameter can be reviewed. Several layers of the skin are imaged in this fashion and reviewed by the dermatopathologist or pathologist, including: the stratum corneum, the stratum granulosum, the stratum spinosum, the epidermal interface and the superficial dermis. Reading these images requires a great deal of skill to interpret.

To determine an appropriate work value for 96934, the RUC reviewed the survey respondents' estimated physician work value and agreed the respondents somewhat overestimated the physician work with the 25th percentile work RVU of 0.79. The specialty society noted and the RUC agreed that the physician work for 96934 and 96936 are identical and therefore should be valued the same. Therefore, the RUC also reviewed the 25th percentile work RVU of 0.76 from survey code 96933 and agreed that this value appropriately accounts for the physician work involved for both 96934 and 96936. To justify a work RVU of 0.76, the RUC reviewed top key reference code 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU=0.75, intra-service time of 25 minutes) and noted both services have identical intra-service time and total time, justifying a similar work value for both services. To further support a work RVU of 0.76, the RUC reviewed CPT code 43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)* (work RVU= 0.81, intra-service time of 20 minutes and total time of 30 minutes) and noted that both codes have similar intensities, while the survey code has more intra-service time and the reference code has more total time. The RUC agreed that both services should be valued similarly. **The RUC recommends a work RVU of 0.76 for CPT code 96934.**

96936 ***Reflectance confocal microscopy (RCM) for cellular and sub-cellular imaging of skin; interpretation and report only, each additional lesion (List separately in addition to primary procedure)***

The RUC reviewed the survey results from 37 dermatologists and dermatopathologists and agreed with the following physician time components: pre-service time of 0 minutes, intra-service time of 25 minutes, and post-service time of 0 minutes.

The specialty society noted when a dermatologist identifies a lesion of concern, in lieu of biopsying the lesion, the dermatologist may order a reflectance confocal microscopy study. The image acquisition entails a nurse or technologist acquiring a series of 0.5mm by 0.5mm

images then the machine's software stitches those images together to form a mosaic image so a lesion of up to 8mm in diameter can be reviewed. Several layers of the skin are imaged in this fashion and reviewed by the dermatopathologist or pathologist, including: the stratum corneum, the stratum granulosum, the stratum spinosum, the epidermal interface and the superficial dermis. Reading these images requires a great deal of skill to interpret.

To determine an appropriate work value for 96936, the RUC reviewed the survey respondents' 25th percentile work value of 0.76 and agreed this value appropriately accounts for the physician work involved. The specialty society noted and the RUC agreed that the physician work for 96934 and 96936 are identical and therefore should be valued the same. To justify a work RVU of 0.76, the RUC reviewed top key reference code 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU=0.75, intra-service time of 25 minutes) and noted both services have identical intra-service time and total time, justifying a similar work value for both services. To further support a work RVU of 0.76, the RUC reviewed CPT code 43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)* (work RVU= 0.81, intra-service time of 20 minutes and total time of 30 minutes) and noted that both codes have similar intensities, while the survey code has more intra-service time and the reference code has more total time. The RUC agreed that both services should be valued similarly. **The RUC recommends a work RVU of 0.76 for CPT code 96936.**

Practice Expense

The practice expense for this issue was reviewed and approved at the previous RUC meeting. At that time the PE Subcommittee discussed at length the 2 minutes of time to *review imaging with interpreting physician.* The PE Subcommittee agreed to leave the time in because for the typical patient the physician doing the imaging and the physician interpreting the imaging are not the same person and the clinical staff needs time to review and verify that the interpreting physician has all the information needed. In addition, the PE Subcommittee allowed one modification at the October 2015 RUC meeting because CMS was concerned about the invoice to price the imaging tray. The invoice shows one price for the tray; however the specialty had itemized the contents of the imaging tray on the PE spreadsheet. The specialty revised the spreadsheet to remove the items of the tray and instead include one line item for *Imaging Tray*. **The RUC reviewed and approved the direct practice expense inputs with modifications at the April 2015 RUC meeting.**

New Technology

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

<u>Insertion of Interlaminar-Interspinous Process Stability-Distraction-Device (Tab 7)</u>

William Creevy, MD (AAOS); Alexander Mason, MD (CNS); Karin Swartz, MD (NASS); John Ratliff, MD (AANS)

At the May 2015 CPT meeting, the CPT Editorial Panel converted two Category III codes to Category I and added two Category III codes to describe the insertion of the interlaminar/interspinous process stability device.

The specialty societies noted that, during their survey process, they learned that a CPT code change proposal to create Category I codes for insertion of spinal stability distraction device without decompression was submitted for consideration for the October 2015 CPT Editorial Panel meeting. The societies noted the codes in this new CPT proposal are closely related to

those that were surveyed for the October 2015 RUC meeting , and therefore, requested for postponing consideration of CPT codes 22840, 228XX1 and 228XX2 until the January 2016 RUC meeting so both code sets could be reviewed simultaneously. **The RUC agreed that the specialty societies should present CPT codes 22840, 228XX and 228X0 at the January 2016 RUC meeting concurrently with the new CPT codes for insertion of spinal stability distraction device without decompression.**

Flexible Laryngoscopy (Tab 8)
Peter Manes, MD (AAO-HNS); Wayne Koch, MD (AAO-HNS); Mark Courey, MD (AAO-HNS)

In the 2015 Medicare Payment Schedule, CMS identified codes 31575 and 31579 as potentially misvalued due to their inclusion on the High Volume Code screen. The specialty society requested, and the RUC approved, referral of the entire flexible laryngoscopy family of codes back to CPT for revision and the addition of several codes representing new technology within this family of services. At the May 2015 CPT meeting the Editorial Panel added three new codes to describe laryngoscopy with ablation or destruction of lesion and therapeutic injection.

31575 Laryngoscopy, flexible; diagnostic
The RUC reviewed the survey results from 205 practicing head and neck surgeons and recommend the following physician time components: pre-service time of 14 minutes, intra-service time of 5 minutes and immediate post-service time of 5 minutes. The RUC noted that this service is typically billed with an Evaluation and Management service because the laryngoscopy is performed immediately following an exam of the larynx and is unplanned. Therefore, the specialty society and RUC agreed to remove 2 minutes of pre-service evaluation time from the survey median time. Finally, the RUC reviewed the remaining 8 minutes of pre-service time evaluation time and agreed that since the physician is spending time explaining the procedure to the patient, including the risks of airway instrumentation and post procedure discomfort, the recommended time is justified.

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile value (work RVU= 1.18) overestimates the physician work involved in CPT code 31575. The specialty society, noting prior discussion with the pre-facilitation committee, revised their initial recommendation and provided an appropriate physician work crosswalk code to value this procedure. The RUC reviewed CPT code 20527 *Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)* (work RVU= 1.00) and noted that while this reference code has less intra-service time compared to the surveyed code, 5 minutes and 8 minutes, respectively, the reference code is a slightly more complex service. Therefore, the RUC agreed that a work RVU of 1.00, a direct physician work crosswalk to 20527, is appropriate for 31575. To justify a work RVU of 1.00, the RUC reviewed the top key reference service 31231 *Nasal endoscopy, diagnostic, unilateral or bilateral* (work RVU= 1.10, intra time= 7 minutes) and agreed with analogous physician work and nearly identical intra-service time, both services should be valued similarly. **The RUC recommends a work RVU of 1.00 for CPT code 31575.**

31576 Laryngoscopy, flexible; with biopsy
The RUC reviewed the survey results from 79 practicing head and neck surgeons and recommend the following physician time components: pre-service time of 25 minutes, intra-service time of 10 minutes and immediate post-service time of 10 minutes. The RUC agreed to add four additional minutes of pre-service scrub, dress and wait time to allow for the

necessary application of a second laryngeal anesthetic for intervention, in addition to the standard nasal anesthetic. Finally, this service is not typically billed with an Evaluation and Management service, as the typical patient is returning for a planned visit following a previous exam of the larynx.

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile work RVU of 1.95 is appropriate for CPT code 31576. To justify a work RVU of 1.95, the RUC compared the surveyed code to CPT codes 58100 *Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method* (work RVU= 1.53, intra time= 10 minutes) and 62310 *Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic* (work RVU= 1.91, intra time= 11 minutes) and agreed that both these services have nearly identical intra-service time and comparable physician work and provide accurate relativity across these families. Finally, the RUC considered other RUC reviewed scope codes and noted the increased intensity for code 31576. This service is a more intense procedure than most 000 day global endoscopy codes because the patient is unsedated, often gagging, coughing and moving during the procedure. There is also additional complexity in talking with the patient while awake, including explaining the risk of the procedure (e.g. aspiration). **The RUC recommends a work RVU of 1.95 for CPT code 31576.**

31577 Laryngoscopy, flexible; with removal of foreign body(s)

The RUC reviewed the survey results from 87 practicing head and neck surgeons and recommend the following physician time components: pre-service time of 23 minutes, intra-service time of 15 minutes and immediate post-service time of 10 minutes. The RUC agreed to add four additional minutes of pre-service scrub, dress and wait time to allow for the necessary application of a second laryngeal anesthetic for intervention, in addition to the standard nasal anesthetic. The RUC noted that this service is typically billed with an Evaluation and Management service because the laryngoscopy is performed immediately following an exam of the larynx and is unplanned. Therefore, the specialty society and RUC agreed to remove 2 minutes of pre-service evaluation time from the survey median time.

The specialty society, noting prior discussion with the pre-facilitation committee, revised their initial recommendation and presented the 25th percentile work RVU of 2.25 as appropriate for CPT code 31577. The RUC agreed that this value provided appropriate relativity within the family of services and across the RBRVS. To justify a work RVU of 2.25, the RUC compared the surveyed code to the top key reference service 43215 *Esophagoscopy, flexible, transoral; with removal of foreign body(s)* (work RVU= 2.54, intra time= 20 minutes) and noted that while both services have comparable physician work, the reference code has 5 additional minutes of intra-service over the surveyed code and is justly valued higher than 31577. In addition, the RUC reviewed MPC codes 52000 *Cystourethroscopy* (work RVU= 2.23, intra time= 15 minutes) and 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU= 2.29, intra time= 15 minutes) and agreed that both these services have identical intra-service time and comparable physician work and provide appropriate brackets above and below the recommended value. **The RUC recommends a work RVU of 2.25 for CPT code 31577**.

31578 Laryngoscopy, flexible; with removal of lesion(s), non-laser

The RUC reviewed the survey results from 60 practicing head and neck surgeons and recommend the following physician time components: pre-service time of 26 minutes, intra-service time of 15 minutes and immediate post-service time of 10 minutes. The RUC agreed to add four additional minutes of pre-service scrub, dress and wait time to allow for the necessary application of a second laryngeal anesthetic for intervention, in addition to the standard nasal anesthetic. Finally, this service is not typically billed with an Evaluation and Management service, as the typical patient is returning for a planned visit following a previous exam of the larynx.

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile value (work RVU= 2.55) overestimates the physician work involved in CPT code 31578. The specialty society, noting prior discussion with the pre-facilitation committee, revised their initial recommendation and provided an appropriate physician work crosswalk code to value this procedure. The RUC reviewed CPT code 43239 *Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple* (work RVU= 2.49, intra time= 15 minutes) and noted that both services have identical intra-service time and represent services with the use of a scope plus an additional intervention. Therefore, the RUC agreed that a work RVU of 2.49, a direct physician work crosswalk to 43239, is appropriate for 31578. To justify a work value of 2.49, the RUC compared the surveyed code to 43239 *Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple* (work RVU= 2.49, intra time= 15 minutes) and agreed that due to identical intra-service time and comparable physician work, the two services should be valued the same. Finally, the RUC noted that 31578, 315X2 and 315X3 all have equal intra-service time and highly analogous physician work and are all correctly valued the same. **The RUC recommends a work RVU of 2.49 for CPT code 31578.**

315X1 Laryngoscopy, flexible; with ablation or destruction of lesion(s) with laser, unilateral

The RUC reviewed the survey results from 58 practicing head and neck surgeons and recommend the following physician time components: pre-service time of 30 minutes, intra-service time of 20 minutes and immediate post-service time of 10 minutes. The RUC agreed to add four additional minutes of pre-service scrub, dress and wait time to allow for the necessary application of a second laryngeal anesthetic for intervention, in addition to the standard nasal anesthetic. Finally, this service is not typically billed with an Evaluation and Management service, as the typical patient is returning for a planned visit following a previous exam of the larynx.

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile value (work RVU= 3.27) overestimates the physician work involved in CPT code 315X1. The specialty society, noting prior discussion with the pre-facilitation committee, revised their initial recommendation and provided an appropriate physician work crosswalk code to value this procedure. The RUC reviewed CPT code 43250 *Esophagogastroduodenoscopy, flexible, transoral; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps* (work RVU= 3.07, intra time= 20 minutes) and noted that both services have identical intra-service time and represent services with the use of a scope plus an additional intervention. Therefore, the RUC agreed that a work RVU of 3.07, a direct physician work crosswalk to 43250, is appropriate for 315X1. To justify a value of 3.07, the RUC compared the surveyed code to 43248 *Esophagogastroduodenoscopy, flexible, transoral; with insertion of guide wire followed by passage of dilator(s) through esophagus over guide wire* (work RVU= 3.01, intra time= 20 minutes) and agreed that these two

analogous services are appropriately valued in close relation to each other. **The RUC recommends a work RVU of 3.07 for CPT code 315X1.**

315X2 Laryngoscopy, flexible; with therapeutic injection(s) (eg, chemodenervation agent or corticosteroid, injected percutaneous, transoral, or via endoscope channel), unilateral
The RUC reviewed the survey results from 62 practicing head and neck surgeons and recommend the following physician time components: pre-service time of 27 minutes, intra-service time of 15 minutes and immediate post-service time of 10 minutes. The RUC agreed to add four additional minutes of pre-service scrub, dress and wait time to allow for the necessary application of a second laryngeal anesthetic for intervention, in addition to the standard nasal anesthetic. Finally, this service is not typically billed with an Evaluation and Management service, as the typical patient is returning for a planned visit following a previous exam of the larynx.

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile value (work RVU= 2.74) overestimates the physician work involved in CPT code 315X2. The specialty society, noting prior discussion with the pre-facilitation committee, revised their initial recommendation and provided an appropriate physician work crosswalk code to value this procedure. The RUC reviewed CPT code 43239 *Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple* (work RVU= 2.49, intra time= 15 minutes) and noted that both services have identical intra-service time and represent services with the use of a scope plus an additional intervention. Therefore, the RUC agreed that a work RVU of 2.49, a direct physician work crosswalk to 43239, is appropriate for 315X2. To justify a work value of 2.49, the RUC compared the surveyed code to code 43239 *Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple* (work RVU= 2.49, intra time= 15 minutes) and agreed that due to identical intra-service time and comparable physician work, the two services should be valued the same. Finally, the RUC noted that 31578, 315X2 and 315X3 all have equal intra-service time and highly analogous physician work and are all correctly valued the same. **The RUC recommends a work RVU of 2.49 for CPT code 315X2.**

315X3 Laryngoscopy, flexible; with injection(s) for augmentation (eg, percutaneous, transoral), unilateral
The RUC reviewed the survey results from 69 practicing head and neck surgeons and recommend the following physician time components: pre-service time of 30 minutes, intra-service time of 15 minutes and immediate post-service time of 10 minutes. The RUC agreed to add four additional minutes of pre-service scrub, dress and wait time to allow for the necessary application of a second laryngeal anesthetic for intervention, in addition to the standard nasal anesthetic. Finally, this service is not typically billed with an Evaluation and Management service, as the typical patient is returning for a planned visit following a previous exam of the larynx.

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile value (work RVU= 3.00) overestimates the physician work involved in CPT code 315X3. The specialty society, noting prior discussion with the pre-facilitation committee, revised their initial recommendation and provided an appropriate physician work crosswalk code to value this procedure. The RUC reviewed CPT code 43239 *Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple* (work RVU= 2.49, intra time= 15 minutes) and noted that both services have identical intra-service time and represent services with the use of a scope plus an additional intervention. Therefore, the RUC agreed that a work RVU of 2.49, a direct physician work crosswalk to 43239, is

appropriate for 315X3. To justify a work value of 2.49, the RUC compared the surveyed code to code 43239 *Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple* (work RVU= 2.49, intra time= 15 minutes) and agreed that due to identical intra-service time and comparable physician work, the two services should be valued the same. Finally, the RUC noted that 31578, 315X2 and 315X3 all have equal intra-service time and highly analogous physician work and are all correctly valued the same. **The RUC recommends a work RVU of 2.49 for CPT code 315X3.**

31579 Laryngoscopy, flexible or rigid telescopic, with stroboscopy
The RUC reviewed the survey results from 103 practicing head and neck surgeons and recommend the following physician time components: pre-service time of 14 minutes, intra-service time of 10 minutes and immediate post-service time of 10 minutes. The RUC noted that this service is typically billed with an Evaluation and Management service because the laryngoscopy is performed immediately following an exam of the larynx and is unplanned. Therefore, the specialty society and RUC agreed to remove 2 minutes of pre-service evaluation time from the survey median time.

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile work RVU of 1.94 is appropriate for CPT code 31576. To justify a work RVU of 1.94, the RUC compared the surveyed code to CPT codes 58100 *Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method* (work RVU= 1.53, intra time= 10 minutes) and 62310 *Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic* (work RVU= 1.91, intra time= 11 minutes) and agreed that both these services have nearly identical intra-service time and comparable physician work and provide accurate relativity across these families. Finally, the RUC considered other RUC reviewed scope codes and noted the increased intensity for code 31579. This service is a more intense procedure than most 000 day global endoscopy codes because the patient is unsedated, often gagging, coughing and moving during the procedure. There is also additional complexity in talking with the patient while awake, including explaining the risk of the procedure (e.g. aspiration). **The RUC recommends a work RVU of 1.94 for CPT code 31579.**

Practice Expense
The PE Subcommittee removed the pre-service time from the non-facility setting to align with the standard for 000 day global services for all services billed on the same day as an evaluation and management (E/M) service. The PE Subcommittee agreed that 30 minutes of clinical staff time for extensive use of clinical staff is necessary for all services performed in the facility setting. The Subcommittee removed 3 minutes to obtain vital signs for CPT code 31575 because it is duplicative of the E/M service. The time was maintained in all other services billed with an E/M because a second set of vital signs is taken when the service becomes more involved with the larynx. Advances in technology and new anesthetic techniques enable the physician to do more with the larynx. These advancements also create more risk and require clinical staff to do real time monitoring. The disposable scope previously included in the *instrument pack, basic ($500-$1499)* (EQ137) is no longer needed for this service; however when it is removed from the pack the remaining equipment still meets the $500 threshold so the pack was maintained for all the services under review other than the 31579, which utilizes a channeled scope. The PE Subcommittee questioned the need for 2 light sources, light, *fiberoptic headlight w-source* (EQ170) and *light source, xenon* (EQ167); however the two are not compatible. The EQ170 is used for the aesthetic and the

EQ167 is used for the scope. The scopes included in the services are slightly different for each service, however the specialty clarified that for all services the scopes in use would be either the *endoscopy, rigid, laryngoscopy* (ES010) or the *fiberscope, flexible, rhinolaryngoscopy* (ES020), but not both and the *video system, endoscopy (processor, digital capture, monitor, printer, cart)* (ES031). For each service except the diagnostic code (31575), the channeled scope would need to be available. For 31579 the *video system, stroboscopy (strobing platform, camera, digital recorder, monitor, printer, cart)* (ES032) is needed rather than the ES031. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

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

<u>Partial Exchange Transfusion (Tab 9)</u>
Steven Krug, MD (AAP); Stephen Pearlman, MD (AAP)

In May 2015, the CPT Editorial Panel established one new code to describe newborn partial exchange transfusion.

At the October 2015 RUC meeting, while reviewing the specialty society's recommendation for new code 364X1, the RUC agreed that CPT codes 36440, 36450, 36455 and 36460 are also part of the same code family and should have been surveyed. The RUC also noted that CPT code 36450, a Harvard valued code, was placed on the reference service list for the RUC survey of 364X1 in error. Therefore, the RUC did not provide a recommendation for 364X1. **The RUC requested that the specialty society survey codes 364XX1, 36440, 36450, 36455 and 36460 for the January 2016 RUC meeting.**

Practice Expense
The Practice Expense Subcommittee reviewed and approved the specialty society's recommendation for no direct practice expense inputs as this service is typically performed in the facility setting. The RUC will consider the Subcommittee's recommendations at the January 2016 RUC meeting.

<u>Epidural Injections (Tab 10)</u>
Marc Leib, MD, JD (ASA); Richard Rosenquist, MD (ASA); Eduardo Fraifeld, MD (AAPM); Karin Swartz, MD (NASS); Kano Mayer, MD (NASS); Barry Smith, MD (AAPMR); Chris Merifield, MD (SIS); Scott Horn, DO (IDSA)

In Final Rule 2015, CMS developed interim final values for 2014 for CPT codes 62310, 62311, 62318 and 62319, which resulted in CY 2014 payment reductions. CMS established final interim values below those recommended by the RUC because they did not believe the RUC recommended work RVUS accounted for the substantial decrease in time it takes to furnish these services. CMS removed the radiographic fluoroscopy room for 62310, 62311 and 62318 and portable C-arm for 62319. Thousands of commenters objected to the CY 2014 interim final values. Additionally, CMS stated that it appears that these services are typically furnished with imaging guidance. Thus, the Agency believes it would be appropriate for the injection and imaging guidance codes to be bundled in the inputs for image guidance to be included in the valuation of the epidural injection codes as it is for transformaminal and paravertebral codes. CMS included CPT codes 62310, 62311, 62318 and 62319 on the potentially misvalued codes list so that they can obtain information to support their valuation with image guidance included.

In September 2014 the RUC referred the codes to the CPT 2017 cycle to ensure that the codes accurately describe the services. In May 2015, the CPT Editorial Panel deleted 62310, 62311, 62318 and 62319, and created eight new codes for epidural injections to differentiate injections with and without imaging guidance.

623X5 Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

The RUC reviewed the survey results from 64 physicians and determined that the survey 25^{the} percentile work RVU of 1.80 appropriately accounts for the work required to perform this service. The RUC reduced the pre-service positioning time as only 3 minutes is necessary for this without imaging guidance service. The RUC recommends 10 minutes pre-service evaluation time, 3 minutes pre-positioning time, 5 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the "with imaging guidance" therapeutic interlaminar injection services require two additional minutes positioning to place lead gowns on the patient and the doctor as well as drape and shield the fluoroscopy machine. The specialty society indicated and the RUC agreed that the therapeutic interlaminar injections that include fluoroscopically guidance are slightly more intense and complex because the patients present marked anatomic changes due to disease and typically present degenerative abnormalities and/or prior surgical intervention. These result in significant changes in skeletal and epidural anatomy that make technical performance more difficult and increase the risk for direct spinal cord injury during needle placement with resultant catastrophic long-term neurologic outcomes. The RUC also agreed that the difference in work RVU increments for this set of services are small yet appropriate due to the multi-faceted nature of the surveys (different total number of respondents and different individuals responding to each code) as well as the different work required with each body location.

The RUC compared the surveyed code to the top two key reference codes 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU = 2.29 and 15 minutes intra-service time) and 64490 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level* (work RVU = 1.82 and 15 minutes intra-service time) and determined that these service require similar work, time, intensity and complexity, therefore the survey 25th percentile work RVU of 1.80 places this service comparably to other services. For additional support the RUC referenced MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.80 for CPT code 623X5.**

623X6 Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

The RUC reviewed the survey results from 124 physicians and determined that the survey 25^{the} percentile work RVU of 1.95 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service evaluation time, 5 minutes pre-positioning time, 5 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the "with imaging guidance"

therapeutic interlaminar injection services require two additional minutes positioning to place lead gowns on the patient and the doctor as well as drape and shield the fluoroscopy machine. The specialty society indicated and the RUC agreed that the therapeutic interlaminar injections that include fluoroscopically guidance are slightly more intense and complex because the patients present marked anatomic changes due to disease and typically present degenerative abnormalities and/or prior surgical intervention. These result in significant changes in skeletal and epidural anatomy that make technical performance more difficult and increase the risk for direct spinal cord injury during needle placement with resultant catastrophic long-term neurologic outcomes. The RUC also agreed that the difference in work RVU increments for this set of services are small yet appropriate due to the multi-faceted nature of the surveys (different total number of respondents and different individuals responding to each code) as well as the different work required with each body location.

The RUC compared the surveyed code to key reference codes 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU = 2.29 and 15 minutes intra-service time) and 64490 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level* (work RVU = 1.82 and 15 minutes intra-service time) and determined that these service require similar work, time, intensity and complexity, therefore the survey 25th percentile work RVU of 1.95 places this service comparably to other services. For additional support the RUC referenced MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.95 for CPT code 623X6.**

623X7 Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

The RUC reviewed the survey results from 76 physicians and determined that the survey 25the percentile work RVU of 1.55 appropriately accounts for the work required to perform this service. The RUC reduced the pre-service positioning time as only 3 minutes is necessary for this without imaging guidance service. The RUC recommends 10 minutes pre-service evaluation time, 3 minutes pre-positioning time, 5 minutes scrub/dress/wait time, 11 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the “with imaging guidance” therapeutic interlaminar injection services require two additional minutes positioning to place lead gowns on the patient and the doctor as well as drape and shield the fluoroscopy machine. The specialty society indicated and the RUC agreed that the therapeutic interlaminar injections that include fluoroscopically guidance are slightly more intense and complex because the patients present marked anatomic changes due to disease and typically present degenerative abnormalities and/or prior surgical intervention. These result in significant changes in skeletal and epidural anatomy that make technical performance more difficult and increase the risk for direct spinal cord injury during needle placement with resultant catastrophic long-term neurologic outcomes. The RUC also agreed that the difference in work RVU increments for this set of services are small yet appropriate due to the multi-faceted nature of the surveys (different total number of respondents and different individuals responding to each code) as well as the different work required with each body location. The RUC noted that the survey respondents indicated 4 minutes less intra-service time compared to the rest of this family of services. The specialty societies and RUC could not justify the

difference, however, the RUC does not accept time above the surveyed time unless a specific survey error is identified.

The RUC compared the surveyed code to key reference codes 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90 and 15 minutes intra-service time) and 62270 *Spinal puncture, lumbar, diagnostic* (work RVU = 1.37 and 20 minutes intra-service time) and determined that these service require similar work, time, intensity and complexity, therefore the survey 25th percentile work RVU of 1.55 places this service comparably to other services. For additional support the RUC referenced MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.55 for CPT code 623X7.**

623X8 Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)

The RUC reviewed the survey results from 162 physicians and determined that the survey 25the percentile work RVU of 1.80 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service evaluation time, 5 minutes pre-positioning time, 5 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the “with imaging guidance” epidural injection services require two additional minutes positioning to place lead gowns on the patient and the doctor as well as drape and shield the fluoroscopy machine. The specialty society indicated and the RUC agreed that “with imaging guidance” epidural injection services are slightly more intense and complex to perform because the physician is working in 1-2 millimeters of space with typical patient that is in more pain and is more challenging than the typical patient receiving an epidural injection without imaging guidance. The RUC also agreed that the difference in work RVU increments for this set of services are small yet appropriate due to the multi-faceted nature of the surveys (different total number of respondents and different individuals responding to each code) as well as the different work required with each body location.

The RUC compared the surveyed code to key reference codes 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90 and 15 minutes intra-service time) and 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU = 2.29 and 15 minutes intra-service time) and determined that these service require similar work, time, intensity and complexity, therefore the survey 25th percentile work RVU of 1.80 places this service comparably to other services. For additional support the RUC referenced MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.80 for CPT code 623X8.**

623X9 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance

The RUC reviewed the survey results from 68 physicians and determined that the survey 25th percentile work RVU of 1.89 appropriately accounts for the work required to perform this service. The RUC reduced the pre-service positioning time as only 3 minutes is necessary for this without imaging guidance service. The RUC recommends 10 minutes pre-service evaluation time, 3 minutes pre-positioning time, 5 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the "with imaging guidance" therapeutic interlaminar injection services require two additional minutes positioning to place lead gowns on the patient and the doctor as well as drape and shield the fluoroscopy machine. The specialty society indicated and the RUC agreed that the therapeutic interlaminar injections that include fluoroscopically guidance are slightly more intense and complex because the patients present marked anatomic changes due to disease and typically present degenerative abnormalities and/or prior surgical intervention. These result in significant changes in skeletal and epidural anatomy that make technical performance more difficult and increase the risk for direct spinal cord injury during needle placement with resultant catastrophic long-term neurologic outcomes. The RUC also agreed that the difference in work RVU increments for this set of services are small yet appropriate due to the multi-faceted nature of the surveys (different total number of respondents and different individuals responding to each code) as well as the different work required with each body location.

The RUC compared the surveyed code to key reference codes 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU = 2.29 and 15 minutes intra-service time) and 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50 and 15 minutes intra-service time) and determined that these service require slightly more work and less total time than the surveyed code, therefore the survey 25th percentile work RVU of 1.89 places this service comparably to other services. For additional support the RUC referenced MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.89 for CPT code 623X9.**

62X10 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)

The RUC reviewed the survey results from 81 physicians and determined that the survey 25the percentile work RVU of 2.20 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service evaluation time, 5 minutes pre-positioning time, 5 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the "with imaging guidance" therapeutic interlaminar injection services require two additional minutes positioning to place lead gowns on the patient and the doctor as well as drape and shield the fluoroscopy machine. The specialty society indicated and the RUC agreed that the therapeutic interlaminar injections that include fluoroscopically guidance are slightly more intense and complex because the patients present marked anatomic changes due to disease and typically present degenerative abnormalities and/or prior surgical intervention. These result in significant changes in skeletal and epidural anatomy that make technical performance more difficult and increase the risk for direct spinal cord injury during needle placement with resultant catastrophic long-term neurologic outcomes. The RUC also agreed that the difference in work RVU increments for this set of services are small yet appropriate due to the multi-faceted nature of the surveys

(different total number of respondents and different individuals responding to each code) as well as the different work required with each body location.

The RUC compared the surveyed code to key reference codes 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU = 2.29 and 15 minutes intra-service time) and 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50 and 15 minutes intra-service time) and determined that these service require similar work, time, intensity and complexity, therefore the survey 25th percentile work RVU of 2.20 places this service comparably to other services. For additional support the RUC referenced MPC codes 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and 15 minutes intra-service time) and 52000 *Cystourethroscopy (separate procedure)* (work RVU = 2.23 and 15 minutes intra-service time). **The RUC recommends a work RVU of 2.20 for CPT code 62X10.**

62X11 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

The RUC reviewed the survey results from 79 physicians and determined that the survey 25the percentile work RVU of 1.78 appropriately accounts for the work required to perform this service. The RUC reduced the pre-service positioning time as only 3 minutes is necessary for this without imaging guidance service. The RUC recommends 10 minutes pre-service evaluation time, 3 minutes pre-positioning time, 5 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the "with imaging guidance" therapeutic interlaminar injection services require two additional minutes positioning to place lead gowns on the patient and the doctor as well as drape and shield the fluoroscopy machine. The specialty society indicated and the RUC agreed that the therapeutic interlaminar injections that include fluoroscopically guidance are slightly more intense and complex because the patients present marked anatomic changes due to disease and typically present degenerative abnormalities and/or prior surgical intervention. These result in significant changes in skeletal and epidural anatomy that make technical performance more difficult and increase the risk for direct spinal cord injury during needle placement with resultant catastrophic long-term neurologic outcomes. The RUC also agreed that the difference in work RVU increments for this set of services are small yet appropriate due to the multi-faceted nature of the surveys (different total number of respondents and different individuals responding to each code) as well as the different work required with each body location.

The RUC compared the surveyed code to key reference codes 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90 and 15 minutes intra-service time) and 64490 *Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level* (work RVU = 1.82 and 15 minutes intra-service time) and determined that these service require similar work, time, intensity and complexity, therefore the survey 25th percentile work RVU of 1.78 places this service comparably to other services. For additional support the RUC referenced MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.78 for CPT code 62X11.**

62X12 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
The RUC reviewed the survey results from 76 physicians and determined that the survey 25the percentile work RVU of 1.90 appropriately accounts for the work required to perform this service. The RUC recommends 10 minutes pre-service evaluation time, 5 minutes pre-positioning time, 5 minutes scrub/dress/wait time, 15 minutes intra-service time and 10 minutes immediate post-service time. The RUC noted that the "with imaging guidance" therapeutic interlaminar injection services require two additional minutes positioning to place lead gowns on the patient and the doctor as well as drape and shield the fluoroscopy machine. The specialty society indicated and the RUC agreed that the therapeutic interlaminar injections that include fluoroscopically guidance are slightly more intense and complex because the patients present marked anatomic changes due to disease and typically present degenerative abnormalities and/or prior surgical intervention. These result in significant changes in skeletal and epidural anatomy that make technical performance more difficult and increase the risk for direct spinal cord injury during needle placement with resultant catastrophic long-term neurologic outcomes. The RUC also agreed that the difference in work RVU increments for this set of services are small yet appropriate due to the multi-faceted nature of the surveys (different total number of respondents and different individuals responding to each code) as well as the different work required with each body location.

The RUC compared the surveyed code to key reference codes 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU = 1.90 and 15 minutes intra-service time) and 36556 *Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older* (work RVU = 2.50 and 15 minutes intra-service time) and determined that these service require similar work, time, intensity and complexity, therefore the survey 25th percentile work RVU of 1.90 places this service comparably to other services. For additional support the RUC referenced MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90 and 15 minutes intra-service time). **The RUC recommends a work RVU of 1.90 for CPT code 62X12.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct practice expense inputs and made several modifications including:
1. Reduced the pre-service time in the nonfacility setting from extensive use of clinical staff to standard use of clinical staff;
2. Reduced the pre-service time in the facility setting from extensive use of clinical staff to minimal use of clinical staff;
3. Added 2 minutes to obtain consent in the nonfacility setting ;
4. Adjusted to the standard clinical labor inputs for digital imaging. ;
5. Increased equipment time for the *stretcher* (EF018) to account for monitoring time to recover the patient for 40 minutes ;
6. Revised equipment from a mobile C-arm to the *room, radiographic-fluoroscopic* (EL014) room and corrected the associated equipment minutes;
7. Reduced 4 minutes of clinical staff time to *Assist physician in performing procedure* for 623X8 because of a change in the physician work intra-service time from 15 to 11 minutes.

The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.

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

<u>Retinal Detachment Repair (Tab 11)</u>
Steve Kamenetzky, MD (AAO); David Glasser, MD (AAO)

CPT codes 67108 and 67113 were identified through the 090-Day Global Post-Operative Visits screen. In October 2014, the CPT Editorial Panel deleted 67112; revised 67107 and codes 67101, 67105, 67107, 67108, 67110 and 67113 were added as part of the family of services to review of physician work and direct practice expense inputs. In April 2015, the RUC recommended to refer 67101 to CPT for revision. The specialty noted that diathermy is no longer used for this procedure and also that they plan on proposing to delete the "1 or more sessions" descriptor language. In May 2015, the CPT Editorial Panel revised 67101 and 67105, two retinal detachment repair codes to exclude "diathermy" and "with or without drainage of subretinal fluid" to update the descriptors and to also remove the reference to "1 or more sessions" so that the services may be valued based on a single session. The global period will change from a 090 day to a 010 day global for these services.

67101 Repair of retinal detachment, including drainage of subretinal fluid when performed; cryotherapy
The RUC reviewed the survey results from 58 ophthalmologists and recommend the following physician time components: pre-service time of 25 minutes, intra-service time of 40 minutes and immediate post-service time of 15 minutes. The RUC also agreed with the specialty society with the following post-operative visits: one-half day discharge management service (99238) and two level three Evaluation and Management office visits (99213).

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile work RVU of 3.50 is an appropriate value for CPT code 67101. To justify a work RVU of 3.50, the RUC compared the surveyed code to the second highest key reference service 12052 *Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU= 2.87, intra time= 30 minutes) and agreed that since the surveyed code has 10 additional minutes of intra-service time over the reference code, it is appropriately valued higher. The RUC also reviewed CPT code 62365 *Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion* (work RVU= 3.93, intra time= 45 minutes) and noted that while both services have comparable physician work, the reference code has slightly more intra-service time and is appropriately valued higher. **The RUC recommends a work RVU of 3.50 for CPT code 67101.**

67105 Repair of retinal detachment including drainage of subretinal fluid when performed; photocoagulation
The RUC reviewed the survey results from 62 ophthalmologists and recommend the following physician time components: pre-service time of 11 minutes, intra-service time of 30 minutes and immediate post-service time of 10 minutes. The RUC also agreed with the specialty society with the following post-operative visits: two level three Evaluation and Management office visits (99213).

The RUC reviewed the survey respondents' estimated work values and agreed that the 25th percentile work RVU of 3.84 is an appropriate value for CPT code 67105. To justify a work RVU of 3.84, the RUC compared the surveyed code to code 64633 *Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint* (work RVU= 3.84, intra time= 30 minutes) and noted that since both codes have identical intra-service time and comparable physician work, they should both be valued the same. The RUC also compared 67105 to 67101 and agreed that while 67101 has 10 additional minutes of intra-service time, 67105 is a more intense procedure and it accurately valued slightly higher. **The RUC recommends a work RVU of 3.84 for CPT code 67105.**

Practice Expense
The RUC reviewed the PE Subcommittee's modifications to the practice expense, which included the removal of duplicative pre-service time due to the inclusion of post-operative office visits and modification of the equipment minutes. The RUC approved these modifications.

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

Abdominal Aorta Ultrasound Screening (Tab 12)
Matthew Sideman, MD (SVS); Robert Zwolak, MD (SVS), David Han, MD (SVS); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Michael Hall, MD (SIR); Jerry Niedzwiecki, MD (SIR)

When Medicare began paying for abdominal aortic aneurysm (AAA) ultrasound screening in CY 2007, CMS created HCPCS code G0389 and set the RVUs at the same level as CPT code 76775 *Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation; limited*. CMS noted in the CY 2007 final rule with comment period that CPT code 76775 was used to report the service when furnished as a diagnostic test and that they believed the service reflected by G0389 used equivalent resources and work intensity to those contained in CPT code 76775. In the CY 2014 proposed rule, based on a RUC recommendation, CMS proposed to replace the ultrasound room included as a direct PE input for CPT code 76775 with a portable ultrasound unit. Since all the RVUs (including the PE RVUs) for G0389 were crosswalked from CPT code 76775, the proposed PE RVUs for G0389 in the CY 2014 proposed rule were reduced significantly as a result of this change to the direct PE inputs for 76775.

However, CMS did not discuss the applicability of this change to G0389 in the proposed rule's preamble and did not receive any comments on G0389 in response to the proposed rule. CMS finalized the change to CPT code 76775 in the CY 2014 final rule with comment period and the corresponding PE RVUs for G0389 were also reduced. Subsequent to the publication of the CY 2014 final rule, a stakeholder suggested that the reduction in the RVUs for G0389 did not accurately reflect the resources involved in furnishing the service and asked that CMS consider using an alternative crosswalk. Specifically, the stakeholder stated that the type of equipment typically used in furnishing G0389 is different than that used for CPT code 76775, the time involved in furnishing G0389 is greater than that of CPT code 76775, and the specialty that typically furnishes G0389 is different than the one that typically furnishes CPT code 76775. The stakeholder suggested an alternative crosswalk of CPT code 76705 *Ultrasound, abdominal, real time with image documentation; limited (eg, single organ, quadrant, follow-up)*. After considering the issue, CMS proposed G0389 as a

potentially misvalued code and sought recommendations regarding the appropriate inputs that should be used to develop RVUs for this code. In response, the RUC, in September 2014, referred G0389 to CPT to transition this code to a Category I code for the 2016 cycle.

The specialty societies indicated, and the RUC agreed, that there is compelling evidence that the physician work has changed for this service based on an original flawed methodology, as well as incorrect assumptions made in the previous valuation. The current work RVU and physician time for CPT code G0389 is based on a CMS crosswalk, not a survey. The G-code is crosswalked to a service performed by a different specialty; the dominant provider for 76775 is Urology with a vignette of renal cyst. Subsequently the practice expense direct inputs were changed because of information that the code was primarily being used in the office as a urinary bladder scan. New CPT code 767X1 was created to describe the appropriate physician work and practice expense direct inputs for abdominal aortic aneurysm (AAA) ultrasound screening.

The dominant provider of the previously billed G-code is internal medicine with nearly 33 percent, yet internal medicine did not participate in the survey. The specialty noted that they have continually called for coverage of the service to be restricted to accredited labs in order to reduce inappropriate claims. The RUC noted that there is nothing in the descriptor to limit the service to accredited labs and prevent use by an internist with a portable device. CMS expressed that they do not base their payment decisions on the best way to provide a service, but rather on who is providing it. **The RUC recommends referring CPT code 767X1 to the Relativity Assessment Workgroup for review in 3 years in order to review the dominant provider after claims data for the new code is available.**

767X1 Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic aneurysm (AAA)
The specialty society, based on the guidance of the RUC, revised their initial recommendation of the survey median work value to the survey 25th percentile. The RUC reviewed the survey results from 211 vascular surgeons and radiologists and determined that the survey 25th percentile work RVU of 0.55 appropriately accounts for the physician work required to provide this service. The RUC recommends the following physician time components: pre-service time of 5 minutes, intra-service time of 10 minutes and post-service time of 5 minutes.

The RUC compared the surveyed service to similar service CPT code 78014 *Thyroid imaging (including vascular flow, when performed); with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)* (work RVU= 0.50, intra time= 10) and agreed that the surveyed code should be valued higher as it is more intense to perform. For additional support, the RUC referenced MPC code 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU= 0.56, intra time= 10 minutes) and CPT code 75571 *Computed tomography, heart, without contrast material, with quantitative evaluation of coronary calcium* (work RVU= 0.58, intra time= 10 minutes). **The RUC recommends a work RVU of 0.55 for CPT code 767X1.**

Practice Expense
The PE Subcommittee reduced the clinical staff time to *prepare room, equipment and supplies* from 4 to 2 minutes. The PE Subcommittee raised concerns that the PE Subcommittee recommendation was prepared by specialty societies that are not the dominant provider of this service according to Medicare claims data. The presenters explained that this

is likely due to increased use of G-code G0389 with a handheld device, which is not the intended use of the CPT code that is currently used as a crosswalk for the G-code. The specialty explained that this service appropriately utilizes an ultrasound room. The presenters explained, and the PE Subcommittee agreed, that this is likely an issue of miscoding. **The RUC recommends that the specialty work with the AMA to develop a CPT Assistant article to clarify appropriate use of the new CPT code 767X1 that will replace the G-code G0389. The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

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

Fluoroscopic Guidance (Tab 13)
Ezequiel Silva III, MD (ACR); Kurt Schoppe, MD (ACR); Marc L. Leib, MD, JD (ASA); Richard Rosenquist, MD (ASA); Michael Hall, MD (SIR)

Facilitation Committee #2

In May 2015, the CPT Editorial Panel deleted 62310, 62311, 62318 and 62319, and created eight new codes for epidural injections to differentiate injections with and without imaging guidance. CPT codes 77001, 77002 and 77003 were included as part of this family to review. The specialty societies requested that these services be reviewed independently from the epidural injection codes since only 77003 relates to spine interventions, 77002 involves body interventions and 77001 relates to central venous catheters. Additionally, CMS requested that all three services be surveyed as add-on (ZZZ global period) services. CMS indicated that while these codes have been classified as stand-alone XXX codes previously, they believe that their vignettes and CPT Manual parentheticals are consistent with an add-on code as has been established for 77001. Therefore, the global periods for 77002 and 77003 reflect an add-on code global of ZZZ with modifications to the vignettes and parentheticals anticipated at the upcoming October 2015 CPT Editorial Panel meeting. The specialty societies performed this survey based on the anticipated update to the vignette.

The RUC discussed the issues with the physician pre-service and post-service time recommended for these ZZZ global period services. The RUC noted that add-on services rarely include pre- and post-service time as that is associated with the base code in which these are reported. The RUC noted that the recommendations for the related epidural injection codes with and without fluoroscopic guidance, reviewed at this meeting, established a difference of two additional minutes of pre-service positioning time for the fluoroscopic guidance as the only difference in physician time. After much deliberation on whether additional pre and post-service time are included in these services the RUC determined that it would be difficult to now recommend 7 minutes pre-service time and 5 minutes immediate post-service time as indicated by the survey respondents. The RUC also discussed the same physician time for all three services (77001, 77002 and 77003) and agreed with the specialty societies that the physician work, intensity and complexity of 7700,1 the central venous catheter code, is less compared to 77002 and, likewise, the physician work, intensity and complexity for 77002 is less than that required to perform 77003. The intensity regarding guidance relates to the nature of the base code with which these services were reported. The intensity and complexity increases as one moves through the body where there are additional anatomy considerations, superficial and deep structures to consider with 77002 and then additional neuro and spinal structures to consider when performing 77003.

77001 Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 52 physicians and recommends maintaining the current work RVU of 0.38 for CPT code 77001. The RUC recommends 2 minutes of positioning time, the additional pre-service time as established for the epidural injection with fluoroscopic guidance codes, and 15 minutes intra-service time. The RUC noted that the 15 minutes of intra-service time is appropriate to account for physician time required to review previous imaging, which the physician only reviews if performing an intervention using fluoroscopic guidance, confirmation of appropriate imaging equipment settings, applying lead gowns to the patient and the physician, draping and placing a shield on the fluoro machine as well as selecting the proper images for documentation; which would typically be included in the intra-service time for add-on codes, not as separate pre- and post-service time. The RUC referenced ZZZ-global period CPT code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38 and 15 minutes intra-service time) and MPC codes 92025 *Computerized corneal topography, unilateral or bilateral, with interpretation and report* (work RVU = 0.35) and 95874 *Needle electromyography for guidance in conjunction with chemodenervation (List separately in addition to code for primary procedure)* (work RVU = 0.37) to support the recommended physician work and time recommended for CPT code 77001. **The RUC recommends a work RVU of 0.38 for CPT code 77001.**

77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 72 physicians and recommends maintaining the current work RVU of 0.54 for CPT code 77002. The RUC recommends 2 minutes of positioning time, the additional pre-service time as established for the epidural injection with fluoroscopic guidance codes, and 15 minutes intra-service time. The RUC noted that the 15 minutes of intra-service time is appropriate to account for physician time required to review previous imaging which the physician only reviews if performing an intervention using fluoroscopic guidance, confirmation of appropriate settings, applying lead gowns to the patient and the physician, draping and placing a shield on the fluoro machine as well as selecting the proper images for documentation; which would typically be included in the intra-service time for add-on codes not as separate pre- and post-service time. The RUC referenced ZZZ-global period CPT code 96571 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)* (work RVU = 0.55 and 15 minutes intra-service time) and MPC codes 93224 *External electrocardiographic recording up to 48 hours by continuous rhythm recording and storage; includes recording, scanning analysis with report, review and interpretation by a physician or other qualified health care professional* (work RVU = 0.52) and 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU = 0.56) to support the recommended physician work and time recommended for CPT code 77002. **The RUC recommends a work RVU of 0.54 for CPT code 77002.**

77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)
The RUC reviewed the survey results from 114 physicians and recommends maintaining the current work RVU of 0.60 for CPT code 77003. The RUC recommends 2 minutes of positioning time, the additional pre-service time as established for the epidural injection with fluoroscopic guidance codes, and 15 minutes intra-service time. The RUC noted that the 15 minutes of intra-service time is appropriate to account for physician time required to review previous imaging which the physician only reviews if performing an intervention using fluoroscopic guidance, confirmation of appropriate settings, applying lead gowns to the patient and the physician, draping and placing a shield on the fluoro machine as well as selecting the proper images for documentation; which would typically be included in the intra-service time for add-on codes not as separate pre- and post-service time. The RUC referenced ZZZ-global period CPT code 96571 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)* (work RVU = 0.55 and 15 minutes intra-service time) and MPC codes 76536 *Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), real time with image documentation* (work RVU = 0.56) and 76700 *Ultrasound, abdominal, real time with image documentation; complete* (work RVU = 0.81) to support the recommended physician work and time recommended for CPT code 77003. **The RUC recommends a work RVU of 0.60 for CPT code 77003.**

Work Neutrality
The RUC noted that CPT code 77003 was bundled into the new epidural injection codes which will result in an 83% decrease in 77003 being reported alone. The RUC's recommendation for the epidural injection codes will result in an overall work savings that should be redistributed back to the Medicare conversion factor.

Practice Expense
The PE Subcommittee made one minor modification correcting the equipment minutes for the PACS workstation. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

<u>Moderate Sedation Services (Tab 14)</u>
Steve Krug (AAP); Katina Nicolacakis, MD (ATS); Richard Wright, MD (ACC); Zeke Silva, MD (ACR); Kurt Schoppe, MD (ACR); Marc Leib, MD, JD (ASA); Richard Rosenquist, MD (ASA); Michael Hall, MD (SIR); Matthew Sideman, MD (SVS); Cliff Kavinsky, MD (SCAI); Michael Main, MD (ASE); Robert Demarco, MD (CHEST); Kevin Kovitz, MD (CHEST); Alan Plummer, MD (ATS)

In February 2015, the CPT Editorial Panel deleted six codes and replaced them with six new codes to accurately describe moderate sedation procedures in 15 minutes increments, as proposed by the Joint CPT/RUC Moderate Sedation Workgroup. The CPT Editorial Panel also made extensive changes to the introductory guidelines, parenthetical notes and Appendix G, including: 1) revision of the Moderate Sedation guidelines by including definitions for pre-, intra-, and post-service work to allow more accurate moderate sedation time reporting; 2) inclusion of a table of time examples to assist users in selection of the appropriate code(s) to report time spent providing moderate sedation services; 3) removal of the moderate sedation symbols (⦿) from the codes included in the *CPT* code set that were noted to

inherently include moderate sedation services; and 4) deletion of the Appendix G section from the CPT code set. These actions will be implemented for CY 2017.

These CPT coding changes were made in follow-up to CMS stating their intent to unbundle moderate sedation services from every code in Appendix G (in the CY 2015 NPRM). In the CY 2016 NPRM, CMS stated that they seek recommendations from the RUC and other stakeholders on the appropriate valuation for moderate sedation services.

991X1 *Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age*
The RUC reviewed the survey results from 61 physicians and agreed with the following physician time components: pre-service time of 0 minutes, intra-service time of 15 minutes, and post-service time of 15 minutes. The RUC noted that the CPT code descriptor encompasses the "initial 15 minutes of intra-service time" which is defined by the CPT introductory language as beginning "…with the administration of the sedating agent(s)." Administration of the sedation agent typically occurs during the pre-service portion of the underlying procedure. The RUC also noted that for 991X1 and 991X2, the physician time should not overlap with the skin-to-skin time of the underlying procedure as the monitoring portion of moderate sedation is performed by clinical staff for these moderate sedation services. The RUC also agreed this service will be exempt from CPT modifier 51 (*Multiple Procedures*). Furthermore, the RUC agreed that 15 minutes of post-service time is appropriate for this service as for a very young patient, the standard of care requires post-service time for 991X1 to ensuring the young patient has recovered from sedation prior to discharge.

The RUC reviewed the respondents' estimated 25th percentile work RVU of 0.50 and agreed with the specialties that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.50, the RUC reviewed CPT code 93268 *External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; includes transmission, review and interpretation by a physician or other qualified health care professional* (work RVU= 0.52, intra-time of 15 minutes, total time of 30 minutes) and noted that both services have identical intra-service and total times and therefore should be valued similarly. The RUC also reviewed CPT code 95927 *Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in the trunk or head* and noted that both services have identical intra-service times and similar total times and therefore should be valued similarly. **The RUC recommends a work RVU of 0.50 for CPT code 991X1.**

991X2 *Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older*
The RUC reviewed the survey results from 391 physicians and agreed with the following physician time components: pre-service time of 0 minutes, intra-service time of 12 minutes, and post-service time of 0 minutes. The RUC noted that the CPT code descriptor encompasses the "initial 15 minutes of intra-service time" which is defined by the CPT

introductory language as beginning "…with the administration of the sedating agent(s)." Administration of the sedation agent typically occurs during the pre-service portion of the underlying procedure. The RUC also noted that for 991X1 and 991X2, the physician time should not overlap with the skin-to-skin time of the underlying procedure as the monitoring portion of moderate sedation is performed by clinical staff for these moderate sedation codes. In addition, the RUC noted a significant bimodal distribution in the survey data for the survey data from gastroenterology with endoscopic procedures relative to the combined data of the respondents from the 10 other specialty societies that surveyed 991X2. Also, the RUC also agreed this service will be exempt from CPT modifier 51 (*Multiple Procedures*).

The RUC reviewed the combined data from respondents' estimated 25th percentile work RVU of 0.25 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 0.25, the RUC reviewed MPC code 93922 *Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)* (work RVU= 0.25, total time of 10 minutes) and noted that both services have similar total time and physician work and therefore should be valued similarly. The RUC also reviewed MPC code 96413 *Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug* (work RVU= 0.28, total time of 13 minutes) and noted that both services have similar total time and physician work and should also be valued similarly. **The RUC recommends a work RVU of 0.25 for CPT code 991X2.**

991X3 ***Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient younger than 5 years of age***

The RUC reviewed the survey results from 37 physicians and agreed with the following physician time components: pre-service time of 15 minutes, intra-service time of 15 minutes, and post-service time of 15 minutes. The RUC noted that the CPT code descriptor encompasses the "initial 15 minutes of intra-service time" which is defined by the CPT introductory language as beginning "…with the administration of the sedating agent(s)." The RUC concurred with the specialty societies that this service has a high intensity in part to the very young age of the patient. The RUC noted that, in addition to being used for acutely ill or injured patients, this service may also be used to sedate a very young patient for a procedure that an older patient could tolerate without moderate sedation. 991X3 requires additional pre-service time relative to 991X4 due to the additional time needed for planning and for explaining the service to the patient's parent(s). For very young children, the standard of care requires more post-service time for 991X3 relative to 991X4 to ensuring the young patient has recovered from sedation prior to discharge.

The RUC reviewed the respondents' estimated median work RVU of 2.20 and agreed that the survey respondents overvalued the physician work involved in performing this service. The specialty society, noting prior discussion with the pre-facilitation committee, revised their initial recommendation and provided an appropriate physician work crosswalk code to value this procedure. To arrive at an appropriate value, the RUC considered the proposed crosswalk code, MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU= 1.90, intra-service time of 15 minutes, total time of 45

minutes), and agreed that since both services have very similar physician work and identical intra-service and total times, both services should be valued identically. The RUC recommends a direct work RVU crosswalk from reference code 54150 to 991X3. To justify a work RVU of 1.90, the RUC reviewed reference code 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level* (work RVU= 1.90, intra-service time of 15 minutes, total time of 49 minutes) and noted that both services involve very similar physician work and have similar physician times. **The RUC recommends a work RVU of 1.90 for CPT code 991X3.**

991X4 ***Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older***
The RUC reviewed the survey results from 31 physicians and agreed with the following physician time components: pre-service time of 10 minutes, intra-service time of 15 minutes, and post-service time of 9 minutes. The RUC noted that the CPT code descriptor encompasses the "initial 15 minutes of intra-service time" which is defined by the CPT introductory language as beginning "…with the administration of the sedating agent(s)." The RUC concurred that sedation of the acutely ill or injured patient with a separate physician for the procedure and sedation entails a different set of risks then the scheduled patient undergoing a diagnostic procedure. For example, the emergency department patient is rarely fasting; a full stomach, intoxication and/or uncontrolled comorbid conditions are not unusual. The physiology of the acutely injured patient is different than the prepared patient in that the high adrenergic state associated with acute injury requires a different set of considerations for appropriate dosing. The patient with severe pain from a dislocated joint or a displaced fracture may require more than a typical dose for weight or repeat dosing.

The specialty societies, noting prior discussion with the pre-facilitation committee, revised their initial recommendation and instead recommended the 25th percentile work RVU of 1.84. The RUC reviewed the respondents' estimated 25th percentile work RVU of 1.84 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 1.84, the RUC reviewed CPT code 64615 *Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)* (work RVU= 1.85, intra-service time of 15 minutes, total time of 35 minutes) and noted that both services have identical intra-service times and similar total times and should therefore be valued similarly. The RUC also reviewed MPC code 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU= 1.90, intra-service time of 15 minutes, total time of 45 minutes) and noted that both services have identical intra-service times and involve similar physician work, though 54150 has somewhat more total time which justifies a somewhat lower value for the survey code. **The RUC recommends a work RVU of 1.84 for CPT code 991X4.**

991X5 ***Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes of intra-service time (List separately in addition to code for primary service)***
CPT code 991X5 was created by the CPT Editorial Panel as a method to report practice expense for when moderate sedation is performed by the same physician or other qualified healthcare professional also performing the underlying procedure in the office setting. The RUC concurred with the Joint CPT/RUC Moderate Sedation workgroup that this service

should be Practice Expense only and not include any physician work time or work RVUs. The RUC noted that there should be no physician time for 991X5, since physician time should not overlap with the skin-to-skin time of the underlying procedure as the monitoring portion of moderate sedation is performed by clinical staff for these moderate sedation services. **The RUC recommends a work RVU of 0.00 for CPT code 991X5.**

991X6 ***Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)***
The RUC reviewed the survey results from 30 physicians and agreed with the following physician time components: pre-service time of 0 minutes, intra-service time of 15 minutes, and post-service time of 0 minutes. The RUC noted this is an add-on service for 991X3 and 991X4 and that it may be billed multiple times based on the length of the moderate sedation intra-service period. The RUC also noted that the CPT code descriptor encompasses "each additional 15 minutes of intra-service time" which is defined by the CPT introductory language as ending "… when the procedure is completed, the patient is stable for recovery status, and the physician or other qualified health care professional providing the sedation ends personal continuous face-to-face time with the patient."

The specialty societies, noting prior discussion with the pre-facilitation committee, revised their initial recommendation and instead recommended the 25th percentile work RVU of 1.25. The RUC reviewed the respondents' estimated 25th percentile work RVU of 1.25 and agreed that this value appropriately accounts for the physician work involved. To justify a work RVU of 1.25, the RUC reviewed MPC code 64480 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)* (work RVU= 1.20, intra-service time of 15 minutes) and noted that both services have identical intra-service times and involve similar physician work and should therefore be valued similarly. The RUC also reviewed CPT code 64636 *Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)* (work RVU= 1.16, intra-service time of 15 minutes) and noted that although both services have identical intra-service times, the survey code involves somewhat more intense physician work. **The RUC recommends a work RVU of 1.25 for CPT code 991X6.**

Practice Expense
The RUC recommends no direct practice expense inputs for codes 991X3, 991X4 and 991X6 as these services are expected to only be performed in the facility setting. The RUC accepted the direct PE inputs for codes 991X1, 991X2 and 991X5 as recommended by the Practice Expense Subcommittee. The practice expense inputs conform to the current CMS approved standard moderate sedation package direct practice expense inputs.

CPT Appendix G Codes
As part of the new coding structure to report moderate sedation services, the Appendix G section of the CPT code set will be deleted and the physician work and direct practice expense inputs for moderate sedation will be unbundled from all applicable services. These actions will be implemented for CY 2017. In preparation for unbundling of moderate sedation from Appendix G, at the April 2015 RUC meeting, the RUC reviewed and approved pre-service time package proxies of either 1B *Straightforward Patient/Straightforward Procedure*

or 2B *Difficult Patient/Straightforward Procedure* for all applicable codes in Appendix G that did not already have an assigned pre-time package.

Appendix G Physician Work RVU

At the October 2015 RUC meeting, the RUC reviewed and approved a methodology for unbundling budget neutral work RVUs from all relevant services in Appendix G as recommended by the Joint CPT/RUC Moderate Sedation Workgroup. The budget neutral outputs from this methodology are for 0.09 work RVUs for all Appendix G services with assigned pre-time package 1B and 0.18 work RVUs for all Appendix G services with assigned pre-time package 2B. *This methodology and the underlying analysis that it is based on are included in a separate attachment with the RUC recommendations submission.*

During its review of the unbundling methodology, the RUC noted that moderate sedation physician work and time were only bundled into the pre-service portion of applicable services in Appendix G. No physician work RVUs were bundled into the codes for any physician time that overlaps with the skin-to-skin time of the underlying procedure. Therefore, the RUC agreed with the Joint CPT/RUC Moderate Sedation Workgroup that it would only be appropriate to unbundle moderate sedation work derived from CPT code 991X2 *Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older*, while also accounting for budget neutrality.

The RUC-approved unbundling methodology involves removing a two-tier budget neutral work RVU from Appendix G codes based on whether the Appendix G code was assigned RUC pre-service time package 1B (5 minutes of Moderate Sedation time) or pre-service time package 2B (10 minutes of Moderate Sedation time). For services that do not have RUC-assigned pre-time packages, the methodology uses the placeholder pre-time packages assigned by the top performing specialties and approved by the RUC at the April 2015 RUC meeting. The budget neutral outputs of the algorithm are based on the RUC recommendation of 0.25 work RVUs for code 991X2.

As part of the underlying analysis for this methodology, the aggregate projected Medicare Utilization for 991X2 was estimated based on the Medicare utilization for existing CPT code *99144 Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional; age 5 years or older, first 30 minutes intra-service time*, as well as the Medicare utilization and the estimated same-day moderate sedation billed together percentage for each stand-along category I code in Appendix G. The total projected utilization for 991X2 is 6,308,491 Medicare claims. The underlying analysis also determined the proportion of these Moderate sedation services that would be performed with codes in Appendix G by pre-time package, as well as the proportion of moderate sedation services performed with underlying procedures outside of Appendix G.

To validate the methodology's output work RVUs of 0.09 and 0.18, the RUC reviewed how it had originally bundled moderate sedation services into 000-day, 010-day, 090-day and XXX global codes in Appendix G. Time for administration of moderate sedation was bundled into Appendix G services based on assigned RUC pre-service time package 1B (5 minutes of Moderate Sedation time) or pre-service time package 2B (10 minutes of Moderate Sedation

time). As administration of Moderate sedation time was added to the pre-service evaluation portion of the underlying procedure (valued at 0.0224 work RVUs per minute), a derived work RVU of 0.11 RVUs for pre-time package 1B and a derived work RVU of 0.22 RVUs for pre-time package 2B can be assumed. The RUC noted that the output of the methodology under review was similar to these derived work values. The RUC agreed that the lower output of the budget neutral methodology was appropriate due to the needed redistribution of projected Medicare savings from the deletion of CPT code 99144.

Based on its approved methodology for unbundling moderate sedation, the RUC recommends removing the following budget-neutral work RVUs from all services with the XXX, 000-day, 010-day and 090-day global periods in Appendix G:

- **0.09 work RVUs from all Appendix G codes with assigned pre-time package of 1B**
- **0.18 from all Appendix G codes with assigned pre-time package 2B.**

The RUC also recommends no work RVU change for any service with the ZZZ global period.

Appendix G Physician Time

The RUC recommends for 5 minutes of pre-service evaluation time to be removed from every Appendix G code with assigned/proxy RUC pre-service time package 1B and 10 minutes of pre-service evaluation time to be removed from every Appendix G code with assigned/proxy RUC pre-service time package 2B. For the four services with the "CMS/Other" physician time source, the RUC recommends deducting the physician time from the total physician time. For the eight XXX and 000-day global services with a Harvard or RUC time source that do not have any pre-service time, the RUC recommends deducting physician time from the intra-service time. *The recommended physician times by code are included in a separate attachment with the RUC recommendations submission.*

Appendix G Direct Practice Expense Inputs
The RUC recommends for all direct practice expense inputs that pertain to moderate sedation to be removed for every service in Appendix G, as recommended in the separately included attachment with the RUC recommendations submission.

Estimated Medicare Utilization
The RUC estimates the following Medicare utilization for CPT codes 991X1-991X6. *The underlying analyses and assumptions these estimates are based on are included in separate attachments with the RUC recommendations submission.*

XI. CMS Request/Relativity Assessment Identified Codes

Anterior Segment Imaging (Tab 15)
Steven Kamenetzky, MD (AAO); David Glasser, MD (AAO); Charlie Fitzpatrick, OD (AAO)

CPT code 92132 was identified through the New Technology/New Services List in April 2010. In January 2015, the Relativity Assessment Workgroup requested that the specialty society submit an action plan to explain what is driving the utilization and whether other measures may be needed, such as a CPT Assistant article. The Workgroup reviewed the action plan submitted by the specialty society and noted that the utilization has grown rapidly.

The RUC recommended that CPT code 92132 be surveyed for October 2015 and 92133 and 92134 were added as part of this family of services.

92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral
The RUC reviewed the survey results from 63 physicians and determined that the survey 25th percentile work RVU of 0.30, lower than the current work RVU, appropriately accounts for the work required to perform this service. The specialty societies decreased the pre-service time from the survey respondent's time as this service is typically reported with an Evaluation and Management service. The RUC further decreased the pre-service evaluation time to 1 minute in order for the physician to review the patient record, reasons for the test and display previous images. The RUC noted that the interpretation and report are included in the intra-service time any immediate post-service time is already captured in the Evaluation and Management service. The RUC recommends 1 minute pre-service evaluation time and 8 minutes intra-service time. The intra-service time includes reviewing multiple 360 degree cross-section images in one area of the anterior segment of the eye.

The RUC compared CPT code 92132 to the top two key reference codes 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU of 0.50 and intra-service time of 10 minutes) and 92025 *Computerized corneal topography, unilateral or bilateral, with interpretation and report* (work RVU = 0.35 and intra-service time of 12 minutes) and noted that the surveyed service requires less physician work and time and is appropriately valued compared to these services. For additional support the RUC referenced similar MPC services 92568 *Acoustic reflex testing, threshold* (work RVU = 0.29) and 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU = 0.32). **The RUC recommends a work RVU of 0.30 for CPT code 92132.**

92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
The RUC reviewed the survey results from 81 physicians and determined that the survey 25th percentile work RVU of 0.40, lower than the current work RVU, appropriately accounts for the work required to perform this service. The specialty societies decreased the pre-service time from the survey respondent's time as this service is typically reported with an Evaluation and Management service. The RUC further decreased the pre-service evaluation time to 1 minute in order for the physician to review the patient record, reasons for the test and display previous images. The RUC noted that the interpretation and report are included in the intra-service time any immediate post-service time is already captured in the Evaluation and Management service. The RUC recommends 1 minute pre-service evaluation time and 10 minutes intra-service time. The RUC compared 92133 to 92132 and agreed that the physician work, time, intensity and complexity are slightly more for 92133. CPT code 92133 requires an increased intensity and number of images to review when examining the optic nerve. The physician considers the more dire consequences to the patient in detecting irreversible damage to the optic nerve and reviews approximately 12 images total of 12 quadrants of the optic nerve for the current images compared to the previous images.

The RUC compared CPT code 92133 to the top two key reference codes 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination*

(eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2) (work RVU of 0.50 and intra-service time of 10 minutes) and 92025 *Computerized corneal topography, unilateral or bilateral, with interpretation and report* (work RVU = 0.35 and intra-service time of 12 minutes) and noted that the surveyed service requires similar physician work and time and is appropriately valued compared to these services. For additional support the RUC referenced similar MPC services 93923 *Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels, or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)* (work RVU = 0.45) and 72114 *Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views* (work RVU = 0.32). **The RUC recommends a work RVU of 0.40 for CPT code 92133.**

92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
The RUC reviewed the survey results from 89 physicians and determined that the survey 25th percentile work RVU of 0.45, lower than the current work RVU, appropriately accounts for the work required to perform this service. The specialty societies decreased the pre-service time from the survey respondent's time as this service is typically reported with an Evaluation and Management service. The RUC further decreased the pre-service evaluation time to 1 minute in order for the physician to review the patient record, reasons for the test and display previous images. The RUC noted that the interpretation and report are included in the intra-service time any immediate post-service time is already captured in the Evaluation and Management service. The RUC recommends 1 minute pre-service evaluation time and 10 minutes intra-service time. The RUC compared 92134 to 92133 and agreed that the physician work, intensity and complexity are slightly more for 92134. CPT code 92134 requires an increased intensity and complexity due to retinal degeneration. The physician reviews more comparisons and is looking at subjective changes in the anatomy for CPT code 92134. The physician's assessment of the images is used to determine whether to provide an intravitreal injection and the consequences are much more immediate in terms of loss of vision for the patient.

The RUC compared CPT code 92134 to the top two key reference codes 92083 *Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (eg, Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)* (work RVU of 0.50 and intra-service time of 10 minutes) and 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.97 and intra-service time of 15 minutes) and noted that the surveyed service requires less physician work and time and is appropriately valued compared to these services. For additional support the RUC referenced similar MPC services 99281 *Emergency department visit for the evaluation and management of a patient,* (work RVU = 0.45) and 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.48). **The RUC recommends a work RVU of 0.45 for CPT code 92134.**

Practice Expense
The Practice Expense Subcommittee made a minor modification reducing the intra-service time and equipment time by one minute. There was confusion about whether these services,

and other diagnostic services, are typically performed in an ophthalmology screening lane. Rather than create an anomaly among ophthalmology services, the Subcommittee maintained the *lane, screening (oph)* (EL006) and will examine this issue further. **The RUC recommends the direct practice expense inputs as modified by the PE Subcommittee.**

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

Prostate Biopsy – Pathology (Tab 16)
Jonathan Myles, MD (CAP); Swati Methrota, MD (ASC); Stephen Black-Shaffer, MD (CAP); and Michael McEachin, MD (CAP)

For CY 2014, CMS modified the code descriptors of G0416 through G0419 so that these codes could be used for any method of prostate needle biopsy services, rather than only for prostate saturation biopsies. Subsequently, CMS discussed prostate biopsies with stakeholders, and reviewed medical literature and Medicare claims data in considering how best to code and value prostate biopsy pathology services. In considering these discussions and review, CMS had become aware that the current coding structure may be confusing, especially since the number of specimens associated with prostate biopsies is relatively homogenous. For example, G0416 (10-20 specimens) represented the overwhelming majority of all Medicare claims submitted for the four G-codes. Therefore, in the interest of both establishing straightforward coding and maintaining accurate payment, CMS believed it would be appropriate to use only one code to report prostate biopsy pathology services. Therefore, CMS proposed to revise the descriptor for G0416 to define the service regardless of the number of specimens, and to delete codes G0417, G0418, and G0419. CMS proposed G0416 as a potentially misvalued code for CY 2015. In September 2014, the RUC recommended that this service be surveyed for work and to review direct practice expense inputs at the April 2015 meeting.

The specialties presented the survey results at the April 2015 RUC meeting. The specialties argued that the survey results were invalid for a number of reasons. First, it is clear to the specialties that the survey respondents did not understand the service being provided. The respondents indicated confusion over the physician work and time required. Second, the survey respondents' comparisons of the surveyed service to the reference services led to a large variability and heterogeneity in survey results. Many of the survey respondents infrequently performed or did not perform their chosen reference service. The specialties determined and the RUC agreed that the work survey results were flawed and provided invalid estimates of physician work and time.

The RUC discussed the CMS imputed work value and determined that it likely undervalues the work of this service. An alternative approach that has been used in the past on occasion, when reliable survey data is impossible to obtain, is the recommendation of an expert panel. The RUC proposed this method and the specialty agreed that they would form an expert panel to determine the work value of this service. The RUC recommended to maintain the current work value of 3.09 as interim and recommended that the specialties convene an expert panel to determine an appropriate work RVU for CPT code G0416 to be presented to the RUC at the October 2015 RUC meeting.

Background

In CY 2009, CMS first implemented a set of four G codes for the surgical pathology of prostate saturation biopsy services. The number of specimens distinguished the codes: 1-20 for G0416, 21-40 for G0417, 41-60 for G0418, and 60+ for G0419. These G codes were developed to address CMS' concern about the large number of CPT code 88305 claims that would be reported. Over the past 4 years, the definitions for all four G codes changed four separate times without corresponding changes in the code number, creating confusion in the marketplace. During this time the RUC and the pathology specialty societies have maintained that the most accurate way to report prostate biopsy examinations is to utilize 88305 and allow the reporting of multiple units.

For CY 2014, CMS modified the code descriptors of G0416 through G0419 so that these codes could be used for any method of prostate needle biopsy services, rather than only for prostate saturation biopsies. Subsequently, CMS discussed prostate biopsies with stakeholders, and reviewed medical literature and Medicare claims data in considering how best to code and value prostate biopsy pathology services. In considering these discussions and review, CMS expressed concern, at the time, that the existing coding structure may have been confusing, especially since the number of specimens associated with prostate biopsies had been relatively homogenous. For example, G0416 (10-20 specimens) represented the overwhelming majority of all Medicare claims submitted for the four G-codes. Consequently, CMS believed it would be appropriate to use only one code to report prostate biopsy pathology services and proposed to revise the descriptor for G0416 to define the service regardless of the number of specimens, and to delete codes G0417, G0418, and G0419. In September 2014, the RUC recommended that this service be surveyed for work and a review of the direct practice expense inputs for the April 2015 meeting.

Originally G0416 was created for the saturation technique only, then it was applied to all prostate biopsy techniques, and now it applies to all prostate biopsy specimens whether it is 1 needle core or 100. This new definition was implemented for January 1, 2015 and has only been in effect for 3 months prior to the survey being conducted. For CY 2015, CPT code G0416 had a physician work value of 3.09. This value and the practice expense inputs had not changed since the code was created in 2009, however in the interim the 88305 technical component was revalued and the professional component reaffirmed. The revised direct practice expense inputs of 88305 had never been accounted for in the value of G0416. The specialty stated their belief that the primary concern of CMS is related to the practice expense component of this code. The practice expense was reviewed at the April 2015 meeting and an approximate 55% reduction in the direct PE inputs was approved by the PE Subcommittee.

Compelling Evidence

There are a number of compelling evidence arguments for a physician work RVU greater than 3.09 for code G0416. The primary reason is evidence that incorrect assumptions were made in the previous valuation of the service. For CY 2009, CMS stated that the initial four services were valued based on the "work and PE values of 15 percent of samples requiring" the level of expertise of CPT code 88305. "The remaining 85 percent of the samples" were stated to "require confirmation of prostate tissue and interpretation indicating the presence of cancer or not since the diagnosis had been identified in the 15 percent of samples." CMS "assigned the work and PE of 88304 to this group of samples." CMS' valuation methodology yielded a work RVU of 3.09 with 182 minutes for G0416.

There is no basis for the statement "the remaining 85 percent of the samples require confirmation of prostate tissue and interpretation indicating the presence of cancer or not

since the diagnosis had been identified in the 15 percent of samples." Each prostate biopsy core needs to be individually evaluated for cancer and, if present, the size and Gleason grade of the cancer must also be determined. This information is then required in the report and is used by the urologist and other physicians in determining patient management and therapeutic options, including whether active surveillance is a patient management option. The physician work of each specimen requires similar amounts of time, intensity, and complexity as the determination of any instance of cancer or other disease process. Therefore, each sample should be valued with the same underlying CPT code, which the specialties agree should be based on CPT code 88305.

It is illogical and inappropriate to separate the samples into groups or to cross-walk any number of specimens to any service other than to 88305. Cross-walking any number of these individual services to any lower level pathology service inappropriately discounts the physician services. Therefore, CMS' use of 88304 to describe the work of evaluating and interpreting any one of the specimens bundled into G0416 undervalues the actual work that is being performed. It is clearly evident that G0416 was valued by CMS under incorrect assumptions which established a flawed methodology and undervalued the services being provided.

An additional incorrect assumption is that the original valuation applied to different code descriptions. CMS altered the descriptions of service of the prostate G codes four times over the past five years. Yet, they have maintained the physician work value and time of G0416 over the same time period. Originally, G0416 was described as the surgical pathology, gross and microscopic examination of prostate needle saturation biopsy sampling, 1-20 specimens. It then changed to 10-20 specimens, and then it changed to 10-20 using any method, and then finally changed to any method any number. The current single code (G0416) could apply to the pathologists' interpretation work of 1 biopsy or the work of 100 biopsies. This means that 3.09 RVUs would apply equally for 1 biopsy as much as for 100 biopsies. The code also now applies to saturation or non-saturation biopsies, which are inherently variations in work. The specialties agree that the current valuation of G0416 is fundamentally flawed and inaccurate based upon the frequently changing descriptor.

Another compelling evidence argument is the anomalous relationship between the code being valued and other codes. The original CPT code that accurately and specifically addresses the full work of the evaluation a single prostate biopsy specimen is 88305. CPT code 88305 has a work RVU of 0.75 and total time of 25 minutes. CMS had stated they believe the typical number of specimens evaluated for prostate biopsies was between 10 and 12, and a CAP review of Medicare's 2013 5% sample also found that 12 specimens were typical. Therefore, the typical G0416 would be valued at 9.00 work RVUs (0.75 x 12). Even using CMS' lower number (10 specimens), would value the work of G0416 at 7.50 work RVUs (0.75 x 10). Both resulting work RVUs are substantially higher than CMS' current value of 3.09, demonstrating an anomalous relationship in the physician work between G0416 and 88305.

Similarly, the total RUC time of one 88305 is 25 minutes. If 12 specimens are typically evaluated, the physician time of G0416 would be 300 minutes (25 x 12 = 300), 5 hours of physician work. CMS assigned a time in 2009 for 10 to 20 specimens of 182 minutes.

In addition, the two other pathology services with the highest RVUs are 88309 and 88356. Both codes were recently reviewed by the RUC with work RVUs of 2.80 and total time of 90 minutes. Both of these services, although highly complex and intense, evaluate only one specimen. The typical use of G0416 is the evaluation of 12 specimens, which inherently

implies that the service is undervalued at 3.09 RVUs in relation to the existing single specimen valuations of 88309 and 88356.

Recommendation

G0416 Surgical pathology, gross and microscopic examinations, for prostate needle biopsy, any method

The specialties developed a vignette that describes 12 site specific biopsies to be typical. This number is based on statistical analysis of the 2013 5% Medicare claims file. The specialties formed an expert panel of 16 physicians from a variety of different practice types, sizes, and locations throughout the United States. The expert panel reviewed the physician work, time, intensity, and the complexity of the typical service provided with code G0416.

The RUC reviewed the expert panel recommendation and determined that a work RVU of 4.00 appropriately accounts for the physicians work required to perform this service. The RUC recommends 120 minutes of intra-service time, with no pre or post time. The expert panel considered several services as potential cross-walks, however the recently reviewed (April 2012) physician work of CPT code 38240 *Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor* (work RVU = 4.00, total time of 120 minutes), was considered the most applicable comparison for time, intensity, and complexity to the surgical pathology examinations of prostate needle biopsy specimens. The specialties and the RUC considered a comparison to CPT code 17313 *Mohs micrographic technique, including removal of all gross tumor, surgical excision of tissue specimens, mapping, color coding of specimens, microscopic examination of specimens by the surgeon, and histopathologic preparation including routine stain(s) (eg, hematoxylin and eosin, toluidine blue), of the trunk, arms, or legs; first stage, up to 5 tissue blocks)* (work RVU = 5.56), but the specialty did not recommend this value as it would make the service a rank order anomaly among the surgical pathology services. The RUC also considered a comparison to CPT code 88309 *Level VI - Surgical pathology* (work RVU = 2.80, 90 minutes intra-service time only) and 88305 *Level IV - Surgical pathology* (work RVU = 0.75, 25 minutes intra-service time only), however the specialties explained that G0416 is a bundled code whereas the surgical pathology codes are valued per specimen. On a biopsy specimen the pathologist gets the history, grosses the specimen, examines under the microscope to get the diagnosis and then writes the report. The most intense part of the service is using the microscope to get the diagnosis, with a bundled specimen the pathologist gains efficiencies because they only get the history, gross the specimen and write the report one time, however they spend the majority of the time using the microscope to get diagnosis for each specimen, which again is the most intense work of the service. In order to accurately value this service the intensity must be greater than surgical pathology services 88309 and 88305 which is the basis of selecting a crosswalk to 38240 at a work value of 4.00. **The RUC recommends a work value of 4.00 for CPT code G0416.**

Practice Expense

The RUC concurred with the specialty that the practice expense was likely the primary reason that CMS had requested for this service to be reviewed. The direct practice expense inputs are based on a crosswalk to CPT code 88305 as it was in 2009, when CPT code G0416 was developed. During this time CPT code 88305 technical component has been revalued. The refined direct PE inputs for 88305 had never been accounted for in the value of G0416. This PE recommendation is based on 12 specimens as presented as typical by the specialties and will result in approximately a 55% reduction in the direct PE inputs for this service. **The RUC reviewed and approved the direct practice expense inputs with minor revisions as**

submitted by the specialty society and approved by the Practice Expense Subcommittee at the April 2015 RUC meeting.

XII. HCPAC Review Board (Tab 17)

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

- The HCPAC reviewed the physician and occupational therapy evaluation and re-evaluation services. The HCPAC recommended the following:

Relative Value Recommendation for CPT 2015: Physical Medicine and Rehabilitation Evaluation Services (97161X-97168X)

<u>**Physical Therapy Evaluation Services**</u>
The American Physical Therapy Association (APTA) surveyed three physical therapy evaluation services (97X61-97X63) and the physical therapy re-evaluation service (97X64).

<u>*Compelling Evidence*</u>
The HCPAC noted that the recommended work RVUs for the physical therapy evaluation codes are work neutral. However, the APTA presented compelling evidence that there is an anomalous relationship between physical therapy services and the office visit codes for the re-evaluation code 97X64. The HCPAC noted that the physical therapy codes are not equivalent to the physician Evaluation and Management codes but have historically been used as a comparison. The physical therapy codes previously have been valued at approximately 88% of Evaluation and Management services. However, currently the re-evaluation code 97002 (work RVU = 0.60) is 62% of a 99213 (work RVU = 0.97) due to the increase to the Evaluation and Management services over the last 20 years since the physical therapy codes were established. **The HCPAC agreed that there was compelling evidence of an anomalous relationship between the code being valued and other codes.**

APTA estimates the low intensity evaluations service will be reported 25 percent, the moderate intensity evaluations will be reported 50 percent and the high intensity evaluations will be reported 25 percent of the current utilization.

97X61 *Physical therapy evaluation; low complexity*
The HCPAC reviewed the survey results from 127 physical therapists for CPT code 97X61 and determined that the survey median work RVU of 0.75 appropriately accounts for the work required to perform this service. The HCPAC recommends pre-service evaluation time of 5 minutes, intra-service time of 20 minutes and immediate post-service time of 12 minutes. The HCPAC noted that the immediate post-service time accurately accounts for the required documentation of body functions and structure measures, actual activity measures and societal function measures. The HCPAC compared the surveyed code to key reference services 99201 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.48) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU =0.93) and determined that the surveyed code ranked appropriately between these two services. The HCPAC also referenced MPC codes 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU = 0.75 and 25 minutes intra-service time), 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU =

0.75 and 20 minutes intra-service time) and 95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional* (work RVU 0.77 and 20 minutes intra-service time). **The HCPAC recommends a work RVU of 0.75 for CPT code 97X61.**

97X62 Physical therapy evaluation; moderate complexity
The HCPAC reviewed the survey results from 136 physical therapists for CPT code 97X62 and determined that the survey median work RVU of 1.18 appropriately accounts for the work required to perform this service. The HCPAC noted that the work RVU for this moderate complexity evaluation is comparable to the work RVU of 1.20 for the current physical therapy evaluation code. The HCPAC recommends pre-service evaluation time of 10 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes. The HCPAC noted that the immediate post-service time accurately accounts for the required documentation of body functions and structure measures, actual activity measures and societal function measures. The HCPAC compared the surveyed code to key reference services 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.93) and 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU =1.42) and determined that the surveyed code ranked appropriately between these two services. The HCPAC also referenced MPC codes 88361 *Morphometric analysis, tumor immunohistochemistry* (work RVU = 1.18 and 40 minutes intra-service time) and 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU = 1.20 and 20 minutes intra-service time). **The HCPAC recommends a work RVU of 1.18 for CPT code 97X62.**

97X63 Physical therapy evaluation; high complexity
The HCPAC reviewed the survey results from 135 physical therapists for CPT code 97X63 determined that the survey median work RVU of 1.50 appropriately accounts for the work required to perform this service. The HCPAC recommends pre-service evaluation time of 10 minutes, intra-service time of 45 minutes and immediate post-service time of 20 minutes. The HCPAC noted that the immediate post-service time accurately accounts for the required documentation of body functions and structure measures, actual activity measures and societal function measures. The HCPAC compared the surveyed code to key reference services 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42) and 92522 *Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)* (work RVU =1.50) and determined that the surveyed code ranked appropriately between these two services. The HCPAC also referenced MPC codes 92014 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits* (work 4RVU = 1.42 and 29 minutes intra-service time) and 95861*Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 29 minutes intra-service time).**The HCPAC recommends a work RVU of 1.50 for CPT code 97X63.**

97X64 Reevaluation of physical therapy established plan of care
The HCPAC reviewed the survey results from 134 physical therapists for CPT code 97X64 and determined that a work RVU of 0.75 appropriately accounts for the work required to perform this service. The HCPAC noted that the typical patients requiring a re-evaluation would have had an initial evaluation that was moderately complex or highly complex. The HCPAC recommends 5 minutes of pre-service evaluation time, 20 minutes intra-service time

and 10 minutes immediate post-service time. APTA recommended and the HCPAC agreed that a crosswalk to CPT code 95992 *Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day* (work RVU 0.75 and 20 minutes intra-service time) was appropriate for this service requiring the same work and intra-service time. The HCPAC also noted that this physical therapy re-evaluation service was appropriately valued the same as the low intensity physical therapy evaluation code. The HCPAC compared the surveyed code to key reference services 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.48) and 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU =0.97) and determined that the surveyed code ranked appropriately between these two services. **The HCPAC recommends a work RVU of 0.75 for CPT code 97X64.**

CPT Code Descriptor
APTA confirmed that the physical therapist is face-to-face the entire service. The HCPAC recommends that CPT finalize the descriptors and insert the intra-service time for each physical evaluation service (20, 30 and 45 minutes) and 20 minutes for the physical therapy re-evaluation as the typical minutes spent with the patient and/or family.

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

Occupational Therapy Evaluation Services
The American Occupational Therapy Association (AOTA) surveyed three occupational therapy evaluation services (97X65-97X67) and the occupational therapy re-evaluation service (97618X).

Compelling Evidence
The AOTA presented compelling evidence that there is an anomalous relationship between occupational therapy services and the Evaluation and Management office visit codes. The HCPAC noted that the occupational therapy codes are not equivalent to the physician Evaluation and Management codes but have historically been used as a comparison. The occupational therapy codes previously have been valued at approximately 88% of Evaluation and Management services. However, currently the occupational therapy evaluation code 97003 (work RVU = 1.20) is 85% of a 99203 and the occupational therapy re-evaluation code 97004 (work RVU = 0.60) is 62% of a 99213 (work RVU = 0.97) due to the increase to the Evaluation and Management services over the last 20 years since the occupational therapy codes were established. **The HCPAC agreed that there was compelling evidence of an anomalous relationship between the code being valued and other codes.**

AOTA estimates the low intensity evaluations service will be reported 50 percent, the moderate intensity evaluations will be reported 40 percent and the high intensity evaluations will be reported 10 percent of the current utilization. Half of occupational therapy patients sustained injuries to the hands or wrists and which are categorized as low intensity.

97X65 Occupational therapy evaluation; low complexity
The HCPAC reviewed the survey results from 152 occupational therapists for CPT code 97X65 and determined that the work RVU of 0.88 below the survey median, appropriately accounts for the work required to perform this service. The HCPAC noted that the survey median was slightly high and therefore AOTA recommended a direct crosswalk to similar service CPT code 92002 *Ophthalmological services: medical examination and evaluation*

with initiation of diagnostic and treatment program; intermediate, new patient (work RVU = 0.88).The HCPAC recommends 5 minutes of pre-service evaluation time, 30 minutes intra-service time and 12 minutes immediate post-service time. AOTA indicated and the HCPAC agreed that the intra-service time for the occupational therapy evaluation services require more time than the physical therapy evaluation services because the occupational therapist spends more time observing and assessing physical and cognitive disabilities. The typical patient receiving occupational therapy is more complex and intense to treat because they typically have additional functional and cognitive disabilities. The HCPAC noted that the immediate post-service time is appropriate to account for the assessment and documentation of the functional and cognitive impairments that were not require more than two decades ago. The HCPAC compared the surveyed code to key reference services 99201 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.48) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU =0.93) and determined that the surveyed code ranked appropriately between these two services. **The HCPAC recommends a work RVU of 0.88 for CPT code 97X65.**

97X66 Occupational therapy evaluation; moderate complexity
The HCPAC reviewed the survey results from 165 occupational therapists for CPT code 97X66 and determined that the current single code occupational therapy evaluation work RVU of 1.20 appropriately accounts for the work required to perform this service. The HCPAC noted that the survey median was slightly high and the 25th percentile was slightly low; therefore AOTA recommended maintaining the current work RVU of 1.20. The HCPAC recommends 10 minutes of pre-service evaluation time, 45 minutes intra-service time and 15 minutes immediate post-service time. AOTA indicated and the HCPAC agreed that the intra-service time for the occupational therapy evaluation services require more time than the physical therapy evaluation services because the occupational therapist spends more time observing and assessing physical and cognitive disabilities. The typical patient receiving occupational therapy is more complex and intense to treat because they typically have additional functional and cognitive disabilities. The HCPAC noted that the immediate post-service time is appropriate to account for the assessment and documentation of the functional and cognitive impairments that were not require more than two decades ago. The HCPAC compared the surveyed code to key reference services 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.93) and 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU =1.42) and determined that the surveyed code ranked appropriately between these two services. **The HCPAC recommends a work RVU of 1.20 for CPT code 97X66.**

97X67 Occupational therapy evaluation; high complexity
The HCPAC reviewed the survey results from 153 occupational therapists for CPT code 97X67 and determined that the work RVU of 1.70 below the survey median, appropriately accounts for the work required to perform this service. The HCPAC noted that the survey median was slightly high and therefore AOTA recommended a direct crosswalk to similar service CPT code 96125 *Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report* (work RVU = 1.70).The HCPAC recommends 10 minutes of pre-service evaluation time, 60 minutes intra-service time and 20 minutes immediate post-service time. The HCPAC noted that crosswalk code 96125 does not have comparable post time because the interpretation and report are included in the intra-service time whereas for occupational therapy evaluations it is included in the immediate-post service time. AOTA indicated and the HCPAC agreed that the intra-service time for the occupational therapy evaluation services

require more time than the physical therapy evaluation services because the occupational therapist spends more time observing and assessing physical and cognitive disabilities. The typical patient receiving occupational therapy is more complex and intense to treat because they typically have additional functional and cognitive disabilities. The HCPAC noted that the immediate post-service time is appropriate to account for the assessment and documentation of the functional and cognitive impairments that were not require more than two decades ago. The HCPAC compared the surveyed code to key reference services 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42) and 96111 *Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (work RVU =2.60) and determined that the surveyed code ranked appropriately between these two services. **The HCPAC recommends a work RVU of 1.70 for CPT code 97X67.**

97X68 Reevaluation of occupational therapy care/established plan of care
The HCPAC reviewed the survey results from 158 occupational therapists for CPT code 97X68 and determined that the survey 25th percentile work RVU of 0.80 appropriately accounts for the work required to perform this service. The HCPAC recommends 5minutes of pre-service evaluation time, 30 minutes intra-service time and 10 minutes immediate post-service time. AOTA indicated and the HCPAC agreed that the intra-service time for the occupational therapy re-evaluation service requires more time than the physical therapy re-evaluation service because the occupational therapist spends more time observing and assessing physical and cognitive disabilities. The typical patient receiving occupational therapy is more complex and intense to treat because they typically have additional functional and cognitive disabilities. The HCPAC noted that the immediate post-service time is appropriate to account for the assessment and documentation of the functional and cognitive impairments that were not require more than two decades ago. The HCPAC compared the surveyed code to key reference services 99201 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.48) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU =0.93) and determined that the surveyed code ranked appropriately between these two services. **The HCPAC recommends a work RVU of 0.80 for CPT code 97X68.**

CPT Code Descriptor
AOTA confirmed that the occupational therapist is face-to-face the entire service. The HCPAC recommends that CPT finalize the descriptors and insert the intra-service time for each physical evaluation service (30, 45 and 60 minutes) and 30 minutes for the occupational therapy re-evaluation service as the typical minutes spent with the patient and/or family.

Practice Expense
The HCPAC recommends the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee.

- **Other Issues**
  Jane White, PhD, RD indicated that HCPAC members may e-mail her information on the status of where their organization is in developing advanced payment models and whether or not a large group would like to work together in the future.

The RUC filed the HCPAC Report.

XIII. Administrative Subcommittee (Tab 18)

Doctor Waldorf, Chair, provided the following report of the Administrative Subcommittee:

- Doctor Waldorf noted that the Administrative Subcommittee serves as experts to maintain the RUC's procedural issues and each member should be knowledgeable on the history of the RUC and its current policies. Therefore the Administrative Subcommittee reviewed the entire Structure and Functions binder, which includes the RUC structure and functions document, rules and procedures document, confidentiality agreement, anti-lobbying policy, annotated notes (history of RUC actions), conflict of interest policy and financial disclosure policy.
- **Parliamentary Procedures – Revise where Sturgis is referenced**
  Doctor Waldorf informed the RUC that the AMA House of Delegates adopted a new code of parliamentary procedure because *Sturgis* will no longer be updated. **The Administrative Subcommittee revised the reference for parliamentary procedures in the RUC Structure and Functions document, Rules and Procedures document and HCPAC Structure and Functions to the *American Institute of Parliamentarians "Standard Code of Parliamentary Procedure".*** The Administrative Subcommittee also noted that a long time correction may be warranted under the Structure and Functions document section II. Objection, striking "In the future" the Process may be used to establish the professional liability components of the RVS, as the RUC already makes PLI recommendations to CMS. **The Administrative Subcommittee recommends revising the following. "The RUC process evolved to also provide recommendations to CMS related to the practice expense <u>and professional liability</u> relative values. ~~It the future the Process may be used to establish the professional liability component of the RVS.~~**

The RUC approved the Administrative Subcommittee Report.

XIV. Practice Expense Subcommittee (Tab 19)

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

- **Post-Procedure Monitoring Equipment**
  The first issue the PE Subcommittee addressed is what equipment is required to recover a patient after moderate sedation wears off, as the patient continues to be recovered. Examples include a variety of procedures where vascular access is required and there is a puncture of a large artery or vein or a puncture biopsy of a viscus or swapping out tubes in a viscus.

  The PE Subcommittee reviewed three groups of procedures reviewed in prior years and determined that the only item of equipment that is standard to all services that require post-procedure monitoring is the s*tretcher* (EF018). Any additional equipment items used for post procedure monitoring not related to moderate sedation will have to be fully justified in the specialty presentation to the PE Subcommittee and in writing on the practice expense summary of recommendation form.
- **Recommendations of Emergent Procedures Workgroup**
  At the January 2015 RUC meeting, during discussion of the direct practice expense inputs for penile trauma repair services (54437 and 54438), the PE Subcommittee considered reducing the pre-service time from the 60 minutes that is standard for most 90 day global services. This notion was met with questions about how we have dealt with emergency surgery in the past. The Subcommittee quickly reviewed records for ruptured AAA and ruptured appendix and found that we had not address such issues in a consistent manner. A workgroup was formed

to examine this issue and determine the universe of codes that would be considered emergent. At the same time CMS provided some guidance in the proposed rule regarding what they might consider appropriate pre-service clinical staff time in the context of an emergently performed procedure.

The Workgroup, chaired by Doctor McGinty, worked hard over a number of long and contentious discussions. As a result of the discussions AMA staff developed an analytic method to define an emergent procedure. The method is summarized in the report and includes:

- Unique Occurrences = number of unique occurrences of the particular HCPCS on carrier 5% file by beneficiary ID and date of service (multiple services on the same day are counted as one occurrence)
- ER visit = number of times an ER visit (CPT 99281-99285) on carrier 5% file occurs on the same day (for the same beneficiary)
- critical care visit in ER = number of times a critical care visit (CPT 99291-99292) with place of service of "emergency room" on carrier 5% file occurs on the same day (for the same beneficiary)
- emergency ambulance = number of times an emergency ambulance service (HCPCS A0427, A0429-A0431, A0433-A0434) on carrier 5% file occurs on the same day (for the same beneficiary)
- outpatient ER service = number of times an emergency service (revenue center codes 0450-0459, 0981) on hospital outpatient 5% file occurs on the same day (for the same beneficiary)
- inpatient admission = number of times a hospital admission (with type of admission = "emergency", "urgent", or "trauma center") on hospital inpatient 5% file occurs on the same day (for the same beneficiary)
- any emergency service = number of times any of the emergency services above occur on the same day (for the same beneficiary)

The Workgroup agreed that the revised data captures the universe of emergency procedures. We look forward to testing this on future codes with the potential to apply this method to all new and revised codes the same way we review codes for E/M services or multiple procedures billed on the same day.

The Workgroup began working through the identified codes and found some that should be reduced to zero pre-service time, some that should be referred to the RAW and some that should be reevaluated by the PE Subcommittee because the Workgroup could not reach consensus on what the pre-service clinical staff time package should be for an emergent procedure. 15 codes will come back to the PE Subcommittee in January for review of pre-service clinical staff time only and we hope that some pattern will emerge that can be applied as a standard to emergent procedures. The codes referred to the RAW fall into the large category of closed treatment of fractures. There is actually no surgical procedure for most of them. About half of the codes are commonly performed by orthopedic surgery and about half are most commonly performed by emergency medicine. The primary rationale, discussed on the July 2015 Workgroup conference call, for sending these codes to the RAW was for consideration of creating a 000 day global. In subsequent discussions, other issues came up such as if the pre-service activities are actually performed in the intra-service or post-service period and whether or not they were performed by clinical staff or the performing proceduralist. If either of these is true there is the potential that these codes would need a full PE review or even a full review of both work and PE.

- **Vital Signs Workgroup**
  The Workgroup was developed when alternative vital signs were discussed at the meeting. There was discussion of pain scales, glaucoma scales and other functional assessments. The PE Subcommittee will convene a Vital Signs Workgroup to be chaired by Doctor Brill to review the issue and present their recommendation to the PE Subcommittee at the January 2016 RUC meeting.
- **Practice Expense Spreadsheet Update Workgroup**
  This Workgroup will be chaired by Doctor Ouzounian and will work with CMS to create a locked down PE spreadsheet so that the lines can't move, the standards apply automatically and the addition occurs automatically for equipment. There are currently two spreadsheets, one for medical and surgical procedures, and an additional spreadsheet for imaging. There are less formal but still consistent differences in the way that nuclear medicine, radiation oncology, pathology and other specialties present their direct practice expense inputs in the current PE spreadsheet. Doctor Phurrough will be part of the group to ensure that what is recommended can be implemented by CMS.
- **Tab 12 – Abdominal Aorta Ultrasound Screening**
  The appropriate specialties are going to be working with CPT Assistant to have an article emphasizing the appropriate use of the new code with an appropriate device and patient.

The RUC approved the Practice Expense Subcommittee Report.

XV. Research Subcommittee (Tab 20)

Doctor Doug Leahy, Chair, provided a summary of the Research Subcommittee report:

- **The Subcommittee reviewed and accepted the June 2015 Research Subcommittee Review report.**
- **An overview of the Subcommittee Structure and Responsibilities was provided during the Research Subcommittee meeting for those members new to the Subcommittee**
- **Review of Specialty Staff Recommendations for Improving the Number of RUC Survey Responses**

In June 2015, AMA staff requested informal feedback from the Research Subcommittee regarding what information the Subcommittee would like for AMA staff to collect to prepare for the Subcommittee's October 2015 deliberation regarding how to increase the average number of survey responses. The Subcommittee requested for AMA staff to reach out to specialties societies regarding how to increase the number of survey responses and this questionnaire was circulated to all specialty staff in July.

AMA Staff received 19 responses to this solicitation. A list of featured recommendations that AMA staff thought the Subcommittee should initially review was provided in the Research agenda materials, in addition to the complete responses.

The Subcommittee discussed the recommendations highlighted by AMA staff, other recommendations from the specialty feedback and newly suggested ideas from Subcommittee members. **The Subcommittee highlighted the following areas that they would like to review in greater detail at future RUC meetings:**

- **Survey Sample Methodology**
- **Audio-visual Education**
- **Incentivizing and Motivating Potential Survey Respondents:**

  - **Evaluation of RUC Online Survey Tool, RUC Survey Instrument and RUC Survey Process in general**

The Chair, Vice Chair and AMA Staff will schedule detailed review of these highlighted topics and ideas for subsequent Research Subcommittee meetings.

- **Refinement of Definition for "Random Sample" and "Targeted Sample"**
At the January meeting, the Subcommittee requested for AMA staff to draft definitions for the terms "targeted" and "random" used in the *Research Subcommittee Guidelines and Requirements Document* for the Subcommittee's review at its April 2015 meeting. At the April 2015 RUC meeting, the Research Subcommittee agreed that the draft definitions will need to undergo further Subcommittee review at the October 2015 meeting prior to the Subcommittee makes a recommendation on implementation**.** During the RUC's *Other Business* discussion at the April 2015 RUC meeting, representatives from several specialties recommended for the "random" definition to also allow them to randomly sample from subsets of their society based on subspecialties and certifications of their general membership.

At the October 2015 Research Subcommittee meeting, the Subcommittee had a robust discussion regarding whether certain types of survey samples should no longer require Research Subcommittee review in the future and whether new more terminology should be developed to describe the types of survey sample methodology. Several Subcommittee members concurred that the "random" requirement should be softened or redefined. Several Subcommittee members conveyed their support for the permission of societies to construct a survey sample that is a random subset of certain targeted populations (ie those members of a Specialty society that hold a certain subspecialty certification) without Research Subcommittee approval. It was noted that this could help mitigate survey fatigue and improve the survey response rate and number of survey responses. A new term for this type of survey sample would likely need to be devised.

The Subcommittee Chair requested for AMA staff to draft updated survey sample terminology and definitions for a survey sampling methodology that would categorize certain targeted groups (ie those members of a society that hold a subspecialty certification) as not requiring Research Subcommittee approval. This methodology could still use a random sampling method of that subset of a specialty society's membership. The Subcommittee would review this draft language electronically prior to the January 2016 RUC meeting

- **"Do you Do letter":**
At the April 2015 RUC meeting, it was brought to the RUC's attention that some societies first send a "do you do" letter to a random subset of their members asking whether or not the recipient performs the service and if they are willing to take a survey. The survey link is then sent to those that responded yes to the "do you do" letter. In the past, these societies have reported this survey sample methodology as a random sample on the Work Summary of Recommendation form. At the April RUC meeting, several RUC members questioned the validity of classifying these surveys as random and stated that it would seem to be a targeted survey and that Research Subcommittee approval would be needed for a targeted survey. The RUC expressed concerns that although the members selected to receive the "do you do" letter are selected randomly, a self-selection bias is introduced when they are asked if they are willing to participate. If it is determined that a "do you do" letter is a valid method, than the language of that letter should be uniform and approved by the RUC. Currently, there is no

RUC policy prohibiting specialties from conducting their surveys in this way. The RUC had referred this issue to the Research Subcommittee to determine whether this method will continue to fall under the definition of a "random sample".

The Subcommittee discussed this issue though was unable to form a consensus on whether this should represent a valid methodology which would not require explicit Research Subcommittee approval. The Chair requested for AMA staff to create a draft "do you do or are you familiar with this procedure" letter for review by the Subcommittee prior to the January 2016 RUC meeting. This issue will be discussed further at or before the January 2016 Research Subcommittee meeting.

- **Research Subcommittee Guidelines and Requirements Document Review**
  The Subcommittee did not propose any changes to the Research Subcommittee Guidelines and Requirements document.

- **Other Business**

Specialty Society Request for Review of Proposed Revisions to Vignettes:

Radiation Treatment Device (CPT codes 77332-77334; 77470)
American Society for Radiation Oncology

ASTRO submitted a request to the Research Subcommittee to review a revised vignette for CPT codes *77332-77334; 77470.*

The following vignettes were approved by the Research Subcommittee:

77332 *Treatment devices, design and construction; simple (simple block, simple bolus)*

> **Research-approved Vignette:** A 74 year-old male presenting with prostate cancer will be treated with radiotherapy ~~requiring~~ **with** the use of simple treatment device.

77333 *Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)*

> **Research-approved Vignette:** A 65 year-old female presenting with breast cancer, initially treated with mastectomy, will be treated with post-operative radiation to the chest wall and regional lymph nodes. Fabrication of bolus material is required.

77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)*

> **Research-approved Vignette:** A 61-year-old female with ~~stage IIIb~~ non-small cell lung cancer presents for design and construction of a customized immobilization device.

77470 *Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)*

> **Research-approved Vignette:** A 68-year-old male with stage IIIA non- small cell lung cancer will be treated with chemo/radiotherapy preoperatively.

The RUC approved the Research Subcommittee Report.

XVI. Relativity Assessment Workgroup (Tab 21)

Doctor Hitzeman provided the following report of the Relativity Assessment Workgroup:

- **New Technology/New Services Action Plan Review**
  Doctor Hitzeman informed the RUC that the Relativity Assessment Workgroup continued its sixth review of new technology/new services. The Workgroup reviewed 99 new technology/new services and the RUC recommends to re-review three families (21011-28047; 29582-29584 and 90867-90869) after more data is available. The RUC also recommends a CPT Assistant article for 29582-29584 to specify which bandage application should be reported based on what is being treated. The remaining services were removed from the list as there was no demonstration of technology diffusion that impacts work or practice expense.

- **CPT Assistant Analysis Action Plan Review**
  Doctor Hitzeman in formed the RUC that at the January 2015 meeting a Workgroup member requested that the Relativity Assessment Workgroup review the effectiveness of the RUC referrals for specialty societies to develop CPT Assistant articles. AMA staff compiled the list of 38 RUC referrals for development of CPT Assistant articles in which an article was published and one year of Medicare utilization data was available. The Workgroup reviewed these 38 services and related CPT Assistant articles. At this meeting t**he Workgroup reviewed action plans regarding the effectiveness of the articles and the RUC recommends the following:**

CPT Code	RAW recommendation
13120-13122	Specialty societies should submit another CPT Assistant article to educate providers on the clinical requirements for reporting these services, addressing the performance requirements and typical uses of all the codes in the family, as well as for the intermediate repair codes (12031-12037). Articles should include detailed descriptions of procedures, including how to differentiate between complex and intermediate repairs. Re-review in 2017.
26080	Maintain and remove from screen. This is a low volume service.
50605	Appropriately performed by general surgeons. Remove from screen.
52214-52240	Specialty societies to develop a CPT Assistant article to address cystourethroscopy with fulguration and include the bladder tumor resection codes. Public and private insurers do not follow the same reporting guidance for bladder tumor codes. Medicare advises that the largest size tumor code be reported no matter how many tumors were resected; however, commercial insurers do not follow Medicare's directives and may allow reporting of all tumors resected based on size of each tumor. Review in 2017.
63056	2009 CPT Assistant article was effective. Remove from screen.
69801	No miscoding is occurring. Research evidence indicates that this is the proper procedure to treat hearing loss, therefore slow increase is appropriate. Remove from screen.
73580	Review in 2017 to determine of 2015 CPT changes were effective.
96920-96922	Specialty societies should develop a CPT Assistant article to ensure the codes are being used correctly. The May 2013 article was limited to a question of treating a scar using the laser codes 96920-96922, stating that would not be

	appropriate, and that 96999, Unlisted special dermatological service or procedure, should be used instead. A comprehensive article, with examples, on the use of the use of the three laser codes is needed. Review again in 2017 after article has taken effect.

- **Flagged Services Action Plan Review**

  Doctor Hitzeman updated the RUC on review of the following specific flagged services:

  Lumbar Arthrodesis (22612)
  In February 2010, this service was identified via the Codes Reported Together 75% or More screen and in 2011 through the CMS High Expenditure Procedural Codes screen. In January 2013, the RAW reviewed 3/4 2012 utilization data and same day reporting together combinations to determine if codes 22612, 22630 and new bundled code 22633 are being reported correctly. The Workgroup agreed with specialty societies that the 9 months of utilization data appear to shifting appropriately. The RUC requested that an action plan be submitted to the RAW to review the utilization data in 2 years (Oct 2015) to confirm. *Note: In September 2014, this service was also reviewed via the Pre-Time Analysis screen in which the RUC recommend to maintain work RVU and adjust the times from pre-time package 4 (40/18/15).* **The RAW determined that these services are being reported appropriately and data show that these services are not typically being reported together. The RAW recommends that these services be marked as complete.**

  Shoulder Arthroscopy (29824, 29826, 29827 & 29828)
  In February 2010, these services were identified via the Codes Reported Together 75% or More screen. In April 2010, the RAW deferred review of the group until the RUC reviewed 29826 in September 2010 as part of the Harvard valued service with utilization over 30,000. The Workgroup recommended that the RUC consider that 29826 is reported as a stand-alone procedure less than 1% of the time per Medicare claims data. The specialty also noted that 29826 should not be converted to a ZZZ global period as the service in the non-Medicare population is typically performed as a stand-alone procedure. Review was deferred until review until after the RUC reviewed 29826 in April 2011. In January 2013, the RAW determined that most codes in this family were recently reviewed and agree with the specialty society to maintain the current values and review in 3 years (October 2015) of utilization for CPT codes 29824 and 29827 to determine if further review of these related codes are being commonly billed with each other (2011 utilization data shows these two codes are billed together less than 50% of the time). The RAW requested that the specialty societies should submit an action plan to address reporting of these services. **The RAW reviewed the data and determined that these services are typically not reported together. The RAW recommends that these services be marked as complete.**

  Radiation Treatment (55875, 77332, 77333, 77334, 77318, 77778 &77790)
  During the April 2015, review of interstitial radiation source codes 77778 and 77790, the RUC requested that the RAW review the percentages in which code 55875, 77332, 77333, 77334 and 77318 are reported on the same patient, on the same day, but by different providers with 77778 and 77790, to determine if there is any duplication of work. The specialty society agreed to clarify at RAW the work processes for treatment of prostate cancer with interstitial radiation and explain what work is performed by which provider. The specialty will also clarify when the work is performed, and when it is reported. **The RAW reviewed the descriptions of work for the urologist and radiation oncologists and determined that there is not duplicative work.**

The urologists inserts the needle and the radiation oncologist removes the needled while dropping seeds.

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

AAFP and ACP submitted a letter indicating that creating Category I codes are not necessary as the G codes are working as intended and the creation of Category I codes would cause redundancy and overlap. The RAW should review this letter and determine if these codes should remain as referred to CPT to create a Category I code so a temporary G code may no longer be necessary.

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

- **Reiteration of Screens**
  Doctor Hitzeman noted that the Relativity Assessment Workgroup re-ran various screens based on new data and identified the following:

  Site of Service (3 codes)
  AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. Three services were identified in which the Medicare data from 2011-2013 indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period. CPT codes 19303, 52601 and 57240 will be placed on the next Level of Interest form for survey.

  Harvard Valued – Medicare Utilization Over 30,000 (7 codes)
  AMA Staff re-ran the Harvard valued codes with utilization over 30,000, based on 2014 Medicare claims data, and identified seven services. CPT codes 10040, 27370, 30140, 31645, 36215, 64418 and 92140 will be placed on the next Level of Interest form for survey.

  CMS/Other Source (1 code)
  AMA Staff re-ran the CMS/Other source codes with 2014 Medicare utilization of 250,000 or more and identified one service. CPT code 71101 will be placed on the next Level of Interest form for survey. The Workgroup recommends that it lower the threshold and analyze CMS/Other source codes with utilization from 100,000 or more at the January 2016 meeting.

  High Volume (23 codes)
  AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013. The query resulted in the identification of 23 services. The Relativity Assessment Workgroup reviewed these services and recommends the following:

CPT Code	RAW Recommendation
17250	Submit action plan for January 2016 explaining high volume growth.
23472	Remove from screen
27370	Submit action plan for January 2016 explaining high volume growth.
29445	Submit action plan for January 2016 explaining high volume growth.
35475	Remove. CCP at October 2015 CPT meeting to address.
35476	Remove. CCP at October 2015 CPT meeting to address.
67028	Submit action plan for January 2016 explaining high volume growth.
73580	Review in 2017 to determine if CPT 2015 change were effective.
76942	Scheduled to review at 2017 Relativity Assessment Workgroup meeting.
77002	Remove, on this RUC agenda.
77014	Submit action plan for January 2016 explaining high volume growth.
92270	Scheduled to review utilization at Sept 2017 Relativity Assessment meeting.
92507	Submit action plan for January 2016 explaining high volume growth.
95831	Submit action plan for January 2016 explaining high volume growth.
95930	Submit action plan for January 2016 explaining high volume growth.
95970	Submit action plan for January 2016 explaining high volume growth.
96102	Submit action plan for January 2016 explaining high volume growth.
96920	Recommended a CPT Assistant article (see above CPT Assistant Analysis review) and review again in 2017.
96921	Recommended a CPT Assistant article (see above CPT Assistant Analysis review) and review again in 2017.
97532	Submit action plan for January 2016 explaining high volume growth.
97597	Review in 2 years (Sept 2017).
97598	Review in 2 years (Sept 2017).
G0250	Submit action plan for January 2016 explaining high volume growth.

High Level E/M in Global Period (9 codes)

A RUC member requested AMA Staff to query all services with Medicare utilization greater than 10,000 that have a level 4 (99214) or level 5 (99215) office visit included in the global period. There were no codes with volume greater than 10,000 that had level 5 visits. Nine services were identified that have a level 4 office visit. **The Relativity Assessment Workgroup reviewed the data and determined that an action plan to justify the 99214 office visit and review if the family of services also have a level 4 visit for the following codes: 15732, 15734, 19303, 44143, 64561, 64581, and 77427. The Workgroup noted that this screen will be complete after these codes are reviewed as the RUC has more rigorously questioned level 4 office visits within a global period in recent years and will going forward.**

- **Informational Items**

  The following documents were filed as informational items: Referrals to the CPT Editorial Panel; Referrals to the CPT Assistant Editorial Board; Potentially Misvalued Services Progress Report and CMS/Relativity Assessment Status Report.

  The RUC approved the Relativity Assessment Workgroup Report.

XVII. MPC Workgroup (Tab 22)

Doctor Verdi DiSesa, Vice-Chair, provided a summary of the Multi-Specialty Points of Comparison Workgroup report:

- Doctor Verdi DiSesa (Vice-Chair) presented the report of the MPC workgroup, as the Workgroup Chair, Geraldine McGinty was not in attendance. Doctor DiSesa explained that after reviewing the Workgroup charge for new members, the members discussed further improvements that could be made to the MPC list. The members agreed that having the specialty societies review the current list, with an eye towards accurate intensity measurements would be beneficial. Furthermore, the specialties will again be encouraged to review the entire MPC list and offer suggestions for new codes to be added or old codes that are no longer appropriate to be removed. It was agreed that a solicitation will be sent out for specialty society review prior to the April 2016 RUC meeting, as the workload for the January 2016 is burdensome for many specialties already.

The RUC approved the MPC Workgroup Report.

XVIII. Emerging CPT/RUC Issues Workgroup (Tab 23)

Doctor Raphaelson, Chair, provided a summary of the Emerging CPT/RUC Issues Workgroup report:

- Doctor Raphaelson explained that this meeting was mainly an organizational meeting. The Workgroup was convened following a September 24 meeting between the Ken Brin, MD, Chair of the CPT Editorial Panel, and Peter Smith, Chair of the RUC, and CMS leadership. In that meeting the Doctor Smith articulated that the RUC has recommended immediate implementation of existing care management/collaboration services
- Work that has been done by the RUC regarding the medical home in a past Workgroup and should be utilized. Doctor David Hitzeman summarized the RUC's work on the development of resource costs for Medical Home (see www.ama-assn.org/go/medicalhome) and the group discussed that this work should serve as a model for other potential Advanced Payment Models that would not be paid on the Medicare Physician Payment Schedule.
- This Workgroup will serve as a pre-facilitation committee for codes that describe non face-to-face work or bundles of work and the Workgroup will help facilitate their passage through CPT and the RUC.

The RUC approved the Emerging CPT/RUC Issues Workgroup Report.

XIX. PLI Workgroup (Tab 24)

Doctor Margaret Neal, Chair, provided a summary of the Professional Liability Insurance Workgroup report:

- Doctor Neal explained that since many of the Workgroup members were new to the Workgroup, AMA staff took time to briefly review the current PLI issues that are still on the table. For instance, CMS proposed to begin conducting annual PLI RVU updates to reflect changes in the mix of practitioners providing services, and to adjust PLI RVUs for risk. Additionally, CMS also proposed to modify the specialty mix assignment methodology to use

an average of the three most recent years of available data instead of a single year of data, as is the current policy.

- Following this discussion, the Workgroup conducted a review of the PLI crosswalk information for new/revised codes. This information is often overlooked but still important because when a new code is reviewed CMS must assign a PLI RVU based on a crosswalk to an existing code. Since the primary criterion for establishing a PLI RVU is the specialty utilization mix, an existing code that contains the same anticipated utilization for the new code should be used, regardless of work RVU. The members also discussed how this information on the SOR could be more visible. One idea would be to move the crosswalk information above the additional rationale section of the SOR, so that the information isn't overlooked.
- The PLI Workgroup will continue to meet to consider CMS proposals on PLI RVUs and work with other applicable Workgroups/Subcommittees on improvements to the PLI update process.

The RUC approved the PLI Workgroup Report.

XX. Joint CPT/RUC Moderate Sedation Workgroup (Tab 25)

Doctor Albert Bothe, Co-chair, provided a summary of the Moderate Sedation report and Doctor Peter Smith, Chair of the RUC, facilitated the RUC's review of how to unbundle Moderate sedation from all services in CPT Appendix G:

- **Review and Discussion of Moderate Sedation Services Valuation (Tab 14)**

The Workgroup and RUC Reviewers discussed the specialty society recommendations for Moderate Sedation codes 991X1-991X6 and provided the presenting societies with feedback pertaining to which recommendations the societies may want to consider amending. The surveying societies for codes 991X3X, 991X4X and 991X6X indicated that they would be submitting updates recommendations to the RUC.

- **Methodology for Unbundling Moderate Sedation services from all codes in CPT Appendix G**

The Workgroup discussed how to handle the unbundling of moderate sedation services from the codes in Appendix G regarding physician work. At the Workgroup meeting, AMA Staff provided an overview of a detailed analysis of one proposed method to unbundle moderate sedation and answered several questions. Following a robust discussion, the Workgroup agreed that this proposed methodology is appropriate and recommended that the full RUC consider adopting this methodology. The budget neutral outputs from this methodology are for 0.09 work RVUs for all Appendix G services with assigned pre-time package 1B and 0.18 work RVUs for all Appendix G services with assigned pre-time package 2B

The Workgroup, with the support of AMA Staff, explained the proposed methodology in detail to the full RUC and answered many questions. During its review of the unbundling methodology, the RUC noted that moderate sedation physician work and time were only bundled into the pre-service portion of applicable services in Appendix G. No physician work RVUs were bundled into the codes for any physician time that overlaps with the skin-to-skin time of the underlying procedure. Therefore, the RUC agreed with the Joint CPT/RUC Moderate Sedation Workgroup that it would only be appropriate to unbundle moderate

sedation work derived from CPT code 991X2 *Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older*, while also accounting for budget neutrality.

This methodology involves removing a two-tier budget neutral work RVU from Appendix G codes based on whether the Appendix G code was assigned RUC pre-service time package 1B (5 minutes of Moderate Sedation time) or pre-service time package 2B (10 minutes of Moderate Sedation time). For services that do not have RUC-assigned pre-time packages, the methodology uses the placeholder pre-time packages assigned by the top performing specialties and approved by the RUC at the April 2015 RUC meeting. The budget neutral outputs of the algorithm are based on the RUC recommendation of 0.25 work RVUs for code 991X2.

As part of the underlying analysis for this methodology, the aggregate projected Medicare Utilization for 991X2 was estimated based on the Medicare utilization for existing CPT code *99144 Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional; age 5 years or older, first 30 minutes intra-service time*, as well as the Medicare utilization and the estimated same-day moderate sedation billed together percentage for each stand-along category I code in Appendix G. The total projected utilization for 991X2 is 6,308,491 Medicare claims. The underlying analysis also determined the proportion of these Moderate sedation services that would be performed with codes in Appendix G by pre-time package, as well as the proportion of moderate sedation services performed with underlying procedures outside of Appendix G.

To validate the methodology's output work RVUs of 0.09 and 0.18, the RUC reviewed how it had originally bundled moderate sedation services into 000-day, 010-day, 090-day and XXX global codes in Appendix G. Time for administration of moderate sedation was bundled into Appendix G services based on assigned RUC pre-service time package 1B (5 minutes of Moderate Sedation time) or pre-service time package 2B (10 minutes of Moderate Sedation time). As administration of Moderate sedation time was added to the pre-service evaluation portion of the underlying procedure (valued at 0.0224 work RVUs per minute), a derived work RVU of 0.11 RVUs for pre-time package 1B and a derived work RVU of 0.22 RVUs for pre-time package 2B can be assumed. The RUC noted that the output of the methodology under review was similar to these derived work values. The RUC agreed that the lower output of the budget neutral methodology was appropriate due to the needed redistribution of projected Medicare savings from the deletion of CPT code 99144.

Based on its approved methodology for unbundling moderate sedation, the RUC recommended removing the following budget-neutral work RVUs from all services with the XXX, 000-day, 010-day and 090-day global periods in Appendix G:

- **0.09 work RVUs from all Appendix G codes with assigned pre-time package of 1B**
- **0.18 from all Appendix G codes with assigned pre-time package 2B.**

The RUC recommended for 5 minutes of pre-service evaluation time to be removed from every Appendix G code with assigned/proxy RUC pre-service time package 1B

and 10 minutes of pre-service evaluation time to be removed from every Appendix G code with assigned/proxy RUC pre-service time package 2B.

In addition, the RUC recommended no work RVU change for any service with the ZZZ global period.

The RUC approved the Joint CPT-RUC Moderate Sedation Workgroup Report.

XXI. Surgical Global Workgroup (Tab 26)

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

Doctor George Williams (Chair) presented the report of the surgical global workgroup to the RUC. Doctor Williams began by noting that since this is a brand new workgroup, the members took time to review the Workgroup's charge, which is mainly to examine CMS proposal to collect data on services performed within the surgical global post-operative period and develop improvements in the RUC review process to ensure confidence in the post-operative visit data. Additionally, the members reviewed the most recent comments submitted to CMS regarding the collection of post-operative visits and also reviewed the Qualtrics survey post-operative visit collection process.

The majority of the Workgroup's time was spent discussing alternate ways to collect post-operative visit data. Members noted that many large hospital systems are already using CPT code 99024, but there are several flaws with this code, namely that it isn't being collected in the hospital and doesn't specific the level of visit. The members noted that one work around would be to create new codes for tracking visits in the hospital.

The Workgroup noted that CMS has yet to release any information regarding their plans related to the collection of post-operative visit data. The Workgroup plans to review the CMS final decisions in the 2016 Final Rule related to the collection of post-operative visits and convene a meeting to discuss.

The RUC approved the Surgical Global Workgroup Report.

XXII. Time/Intensity Workgroup (Tab 27)

Doctor Scott Collins, Chair, provided a summary of the Time/Intensity Workgroup report:

- **An overview of the Workgroup Structure and Responsibilities was provided during the meeting for the members of this newly created Workgroup**

- **Potential Topics for Workgroup to Evaluate and Address at future meetings:**
    - *Current Intensity and Complexity Measures*
    - *Past RUC Efforts to Value Intensity Directly*
    - *Intra-service Work Per Unit of Time (IWPUT) Usage and Calculation*
    - *Time Data*
    - *Extant Databases*
    - *CMS proposals related to Consultant work (ie RAND and Urban Institute studies)*

- *Discuss Code Families with Identical Times but different intensities:* The Chair requested for AMA staff to catalogue codes with identical intra times/ or total times in the same family but have different intensities (values) for the January meeting.

- **Existing RUC Work Intensity Methodologies**

One of the charges of the Time-Intensity Workgroup is to catalog existing RUC methods to determine intensity, verify their applicability and investigate and develop new methods to determine intensity magnitude. Once the Time-Intensity Workgroup is interested in reviewing the topic of survey intensity/complexity in detail, AMA staff could conduct analyses comparing the previous intensity/complexity methodology to the current methodology.

The Chair stated how those survey intensity/complexity (I/C) measures are difficult for many RUC members to understand and their utility should be assessed by the Workgroup in the future. Some Workgroup noted that the current I/C measures are not useful to them whereas another member noted that they find the current measures useful once getting beyond the initial learning curve.

An individual asked about the reporting of median vs mean for the intensity measures. AMA staff and audience members provided historical information on why this change had been previously made several years ago, noting for example how the sample size for respondents selecting the top key reference code is relatively low which may make the median calculation less valid. The Workgroup Chair requested for AMA staff to reach out to several specialties for tabs of the upcoming median and request for them to also calculate the median for their I/C measures, but solely for review by the Time-intensity Workgroup.

One Workgroup member referenced a historical JAMA paper about the Harvard study included in materials. The article mentioned that Hsiao and his colleagues had observed that mental effort judgment, technical skill/physical effort, and psychological stress may potentially be impossible to objectively observe.

The Vice Chair asked the question regarding would it be more appropriate to continue to refine the current system or should the RUC consider adopting a brand new system? One potential alternate system would be the NASA-TLX work intensity scale. Several Workgroup members noted that they would prefer that the RUC tweaks the current process and thinks that completely redoing the process might not be beneficial.

Alternate Intensity Methodologies:
The Workgroup also discussed past alternate RUC methodologies for determining the intensity of physician work. The most commonly used alternate intensity methodologies, other than assignment by expert panel, are the Rasch Analysis of Paired Comparisons and Intensity Magnitude estimation by direct survey. Their future usage currently requires prior authorization by the Research Subcommittee on a case by case basis; they have been used very rarely outside of the five year review process. A Workgroup Member noted that their Specialty society and other societies had previously found this method useful for comparing services within the same specialty, though found that it was not valid for cross-specialty comparison. Regarding the direct intensity survey methodology, it was noted that the Society of Thoracic Surgeons (STS) could be asked at a future date to present information from their experience with using direct intensity surveys during the 5 year review.

- **Extant Data Sources**
  One of the charges of the Time-Intensity Workgroup is to identify sources of extant time data. The Workgroup briefly discussed this topic and agreed to discuss this topic in further detail at a future Workgroup meeting.

- **Statistical Analysis of RUC Time Data**
  The Chair and AMA staff noted that the Workgroup could explore expanding the basic analyses of survey time data or incorporating more advanced statistical measures (ie standard deviation). The Chair and AMA staff will explore what can be done within the RUC Online Survey Process (Qualtrics tool). The Workgroup could weigh whether or not proposed changes should be considered.

- **Other Business**
  There have been no new publicly-available updates from the RAND or Urban Institute studies since the RUC last reviewed their status in early 2015.

  The RUC approved the Time/Intensity Workgroup Report.

The RUC adjourned at 2:09pm

AMA/Specialty Society RVS Update Committee **Tab 17**
Health Care Professionals Advisory Committee Review Board
October 1-2, 2015

Members: Michael Bishop (Chair), Jane White, PhD, RD, FADA (Co-Chair), Dee Adams Nikjeh, PhD, CCC-SLP (Alt. Co-Chair), Margie Andeae, MD, Randy Boldt, PT, Charles Fitzpatrick, OD, Anthony Hamm, DC, Emily Hill, PA-C, Peter Hollmann, MD, Katie Jordan, PT, Paul Pessis, AuD, Randy Phelps, PhD, W. Bryan Sims, DNP, Timothy Tillo, DPM and Doris Tomer, LCSW

I. CMS Update

Doctor Edith Hambrick from CMS attended the HCPAC meeting. Doctor Hambrick stated that CMS is currently writing the Final Rule for 2016, which will be published on or around November 1, 2015.

II. Relative Value Recommendation for CPT 2015: Physical Medicine and Rehabilitation Evaluation Services (97161X-97168X)

<u>**Physical Therapy Evaluation Services**</u>

The American Physical Therapy Association (APTA) surveyed three physical therapy evaluation services (97161X-97163X) and the physical therapy re-evaluation service (97614X).

<u>*Compelling Evidence*</u>

The HCPAC noted that the recommended work RVUs for the physical therapy evaluation codes are work neutral. However, the APTA presented compelling evidence that there is an anomalous relationship between physical therapy services and the office visit codes for the re-evaluation code 97164X. The HCPAC noted that the physical therapy codes are not equivalent to the physician Evaluation and Management codes but have historically been used as a comparison. The physical therapy codes previously have been valued at approximately 88% of Evaluation and Management services. However, currently the re-evaluation code 97002 (work RVU = 0.60) is 62% of a 99213 (work RVU = 0.97) due to the increase to the Evaluation and Management services over the last 20 years since the physical therapy codes were established. **The HCPAC agreed that there was compelling evidence of an anomalous relationship between the code being valued and other codes.**

APTA estimates the low intensity evaluations service will be reported 25 percent, the moderate intensity evaluations will be reported 50 percent and the high intensity evaluations will be reported 25 percent of the current utilization.

97161X *Physical therapy evaluation; low complexity*

The HCPAC reviewed the survey results from 127 physical therapists for CPT code 97161X and determined that the survey median work RVU of 0.75 appropriately accounts for the work required to perform this service. The HCPAC recommends pre-service evaluation time of 5 minutes, intra-service time of 20 minutes and immediate post-service time of 12 minutes. The HCPAC noted that the immediate post-service time accurately accounts for the required documentation of body functions and structure measures, actual activity measures and societal function measures. The HCPAC compared the surveyed code to key reference services 99201 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.48) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU =0.93) and determined that the surveyed code ranked appropriately between

these two services. The HCPAC also referenced MPC codes 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU = 0.75 and 25 minutes intra-service time), 93015 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report* (work RVU = 0.75 and 20 minutes intra-service time) and 95991 *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed; requiring skill of a physician or other qualified health care professional* (work RVU 0.77 and 20 minutes intra-service time). **The HCPAC recommends a work RVU of 0.75 for CPT code 97161X.**

97162X Physical therapy evaluation; moderate complexity
The HCPAC reviewed the survey results from 136 physical therapists for CPT code 97162X and determined that the survey median work RVU of 1.18 appropriately accounts for the work required to perform this service. The HCPAC noted that the work RVU for this moderate complexity evaluation is comparable to the work RVU of 1.20 for the current physical therapy evaluation code. The HCPAC recommends pre-service evaluation time of 10 minutes, intra-service time of 30 minutes and immediate post-service time of 15 minutes. The HCPAC noted that the immediate post-service time accurately accounts for the required documentation of body functions and structure measures, actual activity measures and societal function measures. The HCPAC compared the surveyed code to key reference services 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.93) and 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU =1.42) and determined that the surveyed code ranked appropriately between these two services. The HCPAC also referenced MPC codes 88361 *Morphometric analysis, tumor immunohistochemistry* (work RVU = 1.18 and 40 minutes intra-service time) and 95805 *Multiple sleep latency or maintenance of wakefulness testing, recording, analysis and interpretation of physiological measurements of sleep during multiple trials to assess sleepiness* (work RVU = 1.20 and 20 minutes intra-service time). **The HCPAC recommends a work RVU of 1.18 for CPT code 97162X.**

97163X Physical therapy evaluation; high complexity
The HCPAC reviewed the survey results from 135 physical therapists for CPT code 97163X determined that the survey median work RVU of 1.50 appropriately accounts for the work required to perform this service. The HCPAC recommends pre-service evaluation time of 10 minutes, intra-service time of 45 minutes and immediate post-service time of 20 minutes. The HCPAC noted that the immediate post-service time accurately accounts for the required documentation of body functions and structure measures, actual activity measures and societal function measures. The HCPAC compared the surveyed code to key reference services 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42) and 92522 *Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria)* (work RVU =1.50) and determined that the surveyed code ranked appropriately between these two services. The HCPAC also referenced MPC codes 92014 *Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits* (work 4RVU = 1.42 and 29 minutes intra-service time) and 95861*Needle electromyography; 2 extremities with or without related paraspinal areas* (work RVU = 1.54 and 29 minutes intra-service time).**The HCPAC recommends a work RVU of 1.50 for CPT code 97163X.**

97164X Reevaluation of physical therapy established plan of care
The HCPAC reviewed the survey results from 134 physical therapists for CPT code 97164X and determined that a work RVU of 0.75 appropriately accounts for the work required to perform this service. The HCPAC noted that the typical patients requiring a re-evaluation would have had an initial evaluation that was moderately complex or highly complex. The HCPAC recommends 5minutes of pre-service evaluation time, 20 minutes intra-service time and10 minutes immediate post-service time. APTA recommended and the HCPAC agreed that a crosswalk to CPT code 95992 *Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day* (work RVU 0.75 and 20 minutes intra-service time) was appropriate for this service requiring the same work and intra-service time. The HCPAC also noted that this physical therapy re-evaluation service was appropriately valued the same as the low intensity physical therapy evaluation code. The HCPAC compared the surveyed code to key reference services 99212 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU = 0.48) and 99213 *Office or other outpatient visit for the evaluation and management of an established patient* (work RVU =0.97) and determined that the surveyed code ranked appropriately between these two services. **The HCPAC recommends a work RVU of 0.75 for CPT code 97164X.**

CPT Code Descriptor
APTA confirmed that the physical therapist is face-to-face the entire service. The HCPAC recommends that CPT finalize the descriptors and insert the intra-service time for each physical evaluation service (20, 30 and 45 minutes) and 20 minutes for the physical therapy re-evaluation as the typical minutes spent with the patient and/or family.

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

Occupational Therapy Evaluation Services
The American Occupational Therapy Association (AOTA) surveyed three occupational therapy evaluation services (97165X-97167X) and the occupational therapy re-evaluation service (97618X).

Compelling Evidence
The AOTA presented compelling evidence that there is an anomalous relationship between occupational therapy services and the Evaluation and Management office visit codes. The HCPAC noted that the occupational therapy codes are not equivalent to the physician Evaluation and Management codes but have historically been used as a comparison. The occupational therapy codes previously have been valued at approximately 88% of Evaluation and Management services. However, currently the occupational therapy evaluation code 97003 (work RVU = 1.20) is 85% of a 99203 and the occupational therapy re-evaluation code 97004 (work RVU = 0.60) is 62% of a 99213 (work RVU = 0.97) due to the increase to the Evaluation and Management services over the last 20 years since the occupational therapy codes were established. **The HCPAC agreed that there was compelling evidence of an anomalous relationship between the code being valued and other codes.**

AOTA estimates the low intensity evaluations service will be reported 50 percent, the moderate intensity evaluations will be reported 40 percent and the high intensity evaluations will be reported 10 percent of the current utilization. Half of occupational therapy patients sustained injuries to the hands or wrists and which are categorized as low intensity.

97165X Occupational therapy evaluation; low complexity
The HCPAC reviewed the survey results from 152 occupational therapists for CPT code 97165X and determined that the work RVU of 0.88 below the survey median, appropriately accounts for the work required to perform this service. The HCPAC noted that the survey median was slightly high and therefore AOTA recommended a direct crosswalk to similar service CPT code 92002 *Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient* (work RVU = 0.88).The HCPAC recommends 5 minutes of pre-service evaluation time, 30 minutes intra-service time and 12 minutes immediate post-service time. AOTA indicated and the HCPAC agreed that the intra-service time for the occupational therapy evaluation services require more time than the physical therapy evaluation services because the occupational therapist spends more time observing and assessing physical and cognitive disabilities. The typical patient receiving occupational therapy is more complex and intense to treat because they typically have additional functional and cognitive disabilities. The HCPAC noted that the immediate post-service time is appropriate to account for the assessment and documentation of the functional and cognitive impairments that were not require more than two decades ago. The HCPAC compared the surveyed code to key reference services 99201 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.48) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU =0.93) and determined that the surveyed code ranked appropriately between these two services. **The HCPAC recommends a work RVU of 0.88 for CPT code 97165X.**

97166X Occupational therapy evaluation; moderate complexity
The HCPAC reviewed the survey results from 165 occupational therapists for CPT code 97166X and determined that the current single code occupational therapy evaluation work RVU of 1.20 appropriately accounts for the work required to perform this service. The HCPAC noted that the survey median was slightly high and the 25th percentile was slightly low; therefore AOTA recommended maintaining the current work RVU of 1.20. The HCPAC recommends 10 minutes of pre-service evaluation time, 45 minutes intra-service time and 15 minutes immediate post-service time. AOTA indicated and the HCPAC agreed that the intra-service time for the occupational therapy evaluation services require more time than the physical therapy evaluation services because the occupational therapist spends more time observing and assessing physical and cognitive disabilities. The typical patient receiving occupational therapy is more complex and intense to treat because they typically have additional functional and cognitive disabilities. The HCPAC noted that the immediate post-service time is appropriate to account for the assessment and documentation of the functional and cognitive impairments that were not require more than two decades ago. The HCPAC compared the surveyed code to key reference services 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.93) and 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU =1.42) and determined that the surveyed code ranked appropriately between these two services. **The HCPAC recommends a work RVU of 1.20 for CPT code 97166X.**

97167X Occupational therapy evaluation; high complexity
The HCPAC reviewed the survey results from 153 occupational therapists for CPT code 97167X and determined that the work RVU of 1.70 below the survey median, appropriately accounts for the work required to perform this service. The HCPAC noted that the survey median was slightly high and therefore AOTA recommended a direct crosswalk to similar service CPT code 96125 *Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report* (work RVU = 1.70).The HCPAC recommends 10 minutes of pre-service evaluation time, 60 minutes intra-service time and 20 minutes immediate post-service time. The HCPAC noted that crosswalk code

96125 does not have comparable post time because the interpretation and report are included in the intra-service time whereas for occupational therapy evaluations it is included in the immediate-post service time. AOTA indicated and the HCPAC agreed that the intra-service time for the occupational therapy evaluation services require more time than the physical therapy evaluation services because the occupational therapist spends more time observing and assessing physical and cognitive disabilities. The typical patient receiving occupational therapy is more complex and intense to treat because they typically have additional functional and cognitive disabilities. The HCPAC noted that the immediate post-service time is appropriate to account for the assessment and documentation of the functional and cognitive impairments that were not require more than two decades ago. The HCPAC compared the surveyed code to key reference services 99203 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 1.42) and 96111 *Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report* (work RVU =2.60) and determined that the surveyed code ranked appropriately between these two services. **The HCPAC recommends a work RVU of 1.70 for CPT code 97167X.**

97168X Reevaluation of occupational therapy care/established plan of care
The HCPAC reviewed the survey results from 158 occupational therapists for CPT code 97168X and determined that the survey 25th percentile work RVU of 0.80 appropriately accounts for the work required to perform this service. The HCPAC recommends 5minutes of pre-service evaluation time, 30 minutes intra-service time and 10 minutes immediate post-service time. AOTA indicated and the HCPAC agreed that the intra-service time for the occupational therapy re-evaluation service requires more time than the physical therapy re-evaluation service because the occupational therapist spends more time observing and assessing physical and cognitive disabilities. The typical patient receiving occupational therapy is more complex and intense to treat because they typically have additional functional and cognitive disabilities. The HCPAC noted that the immediate post-service time is appropriate to account for the assessment and documentation of the functional and cognitive impairments that were not require more than two decades ago. The HCPAC compared the surveyed code to key reference services 99201 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU = 0.48) and 99202 *Office or other outpatient visit for the evaluation and management of a new patient* (work RVU =0.93) and determined that the surveyed code ranked appropriately between these two services. **The HCPAC recommends a work RVU of 0.80 for CPT code 97168X.**

CPT Code Descriptor
AOTA confirmed that the occupational therapist is face-to-face the entire service. The HCPAC recommends that CPT finalize the descriptors and insert the intra-service time for each physical evaluation service (30, 45 and 60 minutes) and 30 minutes for the occupational therapy re-evaluation service as the typical minutes spent with the patient and/or family.

Practice Expense
The HCPAC recommends the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee.

III. Other Issues
Jane White, PhD, RD indicated that HCPAC members may e-mail her information on the status of where their organization is in developing advanced payment models and whether or not a large group would like to work together in the future.

AMA/Specialty Society RVS Update Committee **Tab 18**
Administrative Subcommittee
October 1, 2015

Members: Doctors James Waldorf (Chair), Holly Stanley (Vice Chair), Amr Abouleish, Michael Bishop, Gregory DeMeo, Anthony Hamm, DC, John Lanza, Swati Mehrotra, Joseph Schlecht, and Eugene Sherman.

I. Introductions

Doctor James Waldorf is currently serving as Chair and Doctor Holly Stanley is serving as the Vice Chair of the Administrative Subcommittee. The members of the Administrative Subcommittee will serve on this Subcommittee of the RUC for two years.

II. Review of Structure, Functions and Policies of the RUC

The Administrative Subcommittee reviewed the entire Structure and Functions binder, which includes the RUC structure and functions document, rules and procedures document, confidentiality agreement, anti-lobbying policy, annotated notes (history of RUC actions), conflict of interest policy and financial disclosure policy. The Administrative Subcommittee serves as experts to maintain the RUC's procedural issues and each member should be knowledgeable on the history of the RUC and its current policies.

III. Parliamentary Procedures – Revise where Sturgis is referenced

The AMA House of Delegates adopted a new code of parliamentary procedure because *Sturgis* will no longer be updated. **The Administrative Subcommittee revised the reference for parliamentary procedures in the RUC Structure and Functions document, Rules and Procedures document and HCPAC Structure and Functions to the *American Institute of Parliamentarians "Standard Code of Parliamentary Procedure".*** The Administrative Subcommittee also noted that a long time correction may be warranted under the Structure and Functions document section II. Objection, striking "In the future" the Process may be used to establish the professional liability components of the RVS, as the RUC already makes PLI recommendations to CMS. **The Administrative Subcommittee recommends revising the following. "The RUC process evolved to also provide recommendations to CMS related to the practice expense <u>and professional liability</u> relative values. ~~It the future the Process may be used to establish the professional liability component of the RVS.~~**

Members Present: Scott Manaker, MD, PhD, FCCP (Chair), David C. Han, MD (Vice Chair), Albert Bothe, MD (CPT), Jennifer Aloff, MD, Gregory L. Barkley, MD, Eileen Brewer, MD, Joel V. Brill, MD, Joseph Cleveland, MD, Neal H. Cohen, MD, Thomas Cooper, MD, Mollie MacCormack, MD, FAAD, Geraldine B. McGinty, MD, Margaret Neal, MD, Mary Newman, MD, Tye Ouzounian, MD, John A. Seibel, MD, MACE, Stephen Sentovich, MD, W. Bryan Sims, DNP, APRN-BC, FNP, Lloyd S. Smith, DPM, Robert J. Stomel, DO

I. Post-Procedure Monitoring Equipment

At the January 2014 Practice Expense (PE) Subcommittee Meeting the Subcommittee reviewed and approved the recommendations of The Moderate Sedation Monitoring Time Workgroup. The Workgroup's recommendation was limited to 56 codes under review and standardized clinical staff time for post-procedure moderate sedation monitoring as well as post-procedure monitoring not related to moderate sedation. The Workgroup also recommended that the 56 codes included in the review should maintain an RN as the clinical staff type for post-procedure monitoring not related to moderate sedation. Previously the PE Subcommittee standard did not separate post-procedure monitoring clinical staff time related to moderate sedation and not related to moderate sedation. The RUC currently has a standard package for moderate sedation that includes equipment standards; however when there is monitoring not related to moderate sedation the equipment varies. Often specialty societies list the same equipment that is used for moderate sedation monitoring for post procedure monitoring not related to moderate sedation. The Center for Medicare and Medicaid Services (CMS) brought up the issue at the April 2015 RUC meeting and have requested that the PE Subcommittee discuss equipment standards for post-procedure monitoring not related to moderate sedation at the October 2015 RUC meeting.

Since the Moderate Sedation Monitoring Time Workgroup made their recommendation, the PE Subcommittee has reviewed tabs that require both monitoring time related and unrelated to moderate sedation. Some examples of recently approved tabs include the Genitourinary Catheter Procedures and the Percutaneous Biliary Procedures both of which have 1 hour of monitoring following moderate sedation and 3 subsequent hours of non-moderate sedation monitoring. The two families all have the standard moderate sedation package equipment: *table, instrument, mobile (*EF027); *ECG, 3-channel (with Sp02, NIBP, temp, resp)* (EQ011); *IV infusion pump* (EQ032); *stretcher* (EF018); for the total hours of monitoring time. The Interstitial Radiation Source code has 2 hours of post-procedure monitoring not related to moderate sedation and only utilizes the *stretcher* (EF018) for that time. The Sclerotherapy code has 1 hour of post-procedure monitoring not related to moderate sedation and utilizes both the *table, instrument, mobile (*EF027) and the *stretcher* (EF018) for that time.

The PE Subcommittee discussed the issue and determined that the only item of equipment that is standard to all services that require post-procedure monitoring is the s*tretcher* (EF018). Any additional equipment items used for post procedure monitoring not related to moderate sedation will have to be fully justified in the specialty presentation to the PE Subcommittee and in writing on the practice expense summary of recommendation form.

The PE Subcommittee recommends that only a *stretcher* (EF018) be standard equipment for all services that require post procedure monitoring not related to moderate sedation.

II. Recommendations of Emergent Procedures Workgroup

At the January 2015 RUC meeting, during discussion of the direct practice expense inputs for penile trauma repair services (54437 and 54438), the PE Subcommittee considered reducing the pre-service time from 60 minutes to 15 minutes based on a direct crosswalk to CPT code 44950 *Appendectomy.* The PE Subcommittee noted that CPT code 44960 *Appendectomy; for ruptured appendix with abscess or generalized peritonitis* also has 15 minutes of pre-service time. The PE Subcommittee discussed that there was some precedent for reducing the amount of pre-service time from the 60 minutes that is standard for most 90 day global services for emergency surgery, however the Subcommittee and the RUC have previously accepted varying time elements for emergent procedures. The PE Subcommittee is concerned about 60 minutes of pre-service time in the facility setting for emergency 90 day globals, since clinical staff in the office may not have the opportunity to perform the same pre-service activities.

For the April RUC meeting AMA staff queried emergency department services (99281-99285) billed together with a surgical service on the same day. Staff determined that although there was a precedent for 15 minutes of pre-service time as is allocated to the appendectomy codes, in practice no reduction was applied and most emergent 90 day globals had retained 60 minutes of pre-service time in the facility setting. The PE Subcommittee determined that a Workgroup should be formed to examine the issue. The Chair of the workgroup is Doctor Geraldine McGinty and the members of the workgroup are Doctors David Han, Alan Lazaroff, Joel Brill and Tye Ouzounian. It was determined that the Emergent Procedures Workgroup will provide a recommendation to the PE Subcommittee at the October 2015 PE Subcommittee Meeting.

The Emergent Procedures Workgroup met on May 11, 2015 via conference call and reviewed the data presented at the April 2015 RUC meeting. The Workgroup reviewed the data presented at the April 2015 RUC meeting and determined that there were emergency procedures missing from the list of services. The Workgroup determined that criteria used to determine emergent procedures should be expanded.

The Emergent Procedures Workgroup met on June 23, 2015 via conference call and reviewed the revised data which uses the following 2013 Medicare 5% Standard Analytic Files:

- Carrier 5% file (professional claims)
- Outpatient hospital 5% file
- Inpatient hospital 5% file

The global period is based on the 2015 Medicare physician fee schedule and shows 000, 010 or 090 day global period matched with same beneficiary/same date emergency services. The following are the definitions of variables used to identify the services:

- Unique Occurrences = number of unique occurrences of the particular HCPCS on carrier 5% file by beneficiary ID and date of service (multiple services on the same day are counted as one occurrence)
- ER visit = number of times an ER visit (CPT 99281-99285) on carrier 5% file occurs on the same day (for the same beneficiary)
- critical care visit in ER = number of times a critical care visit (CPT 99291-99292) with place of service of "emergency room" on carrier 5% file occurs on the same day (for the same beneficiary)
- emergency ambulance = number of times an emergency ambulance service (HCPCS A0427, A0429-A0431, A0433-A0434) on carrier 5% file occurs on the same day (for the same beneficiary)

- outpatient ER service = number of times an emergency service (revenue center codes 0450-0459, 0981) on hospital outpatient 5% file occurs on the same day (for the same beneficiary)
- inpatient admission = number of times a hospital admission (with type of admission = "emergency", "urgent", or "trauma center") on hospital inpatient 5% file occurs on the same day (for the same beneficiary)
- any emergency service = number of times any of the emergency services above occur on the same day (for the same beneficiary)

The Workgroup agreed that the revised data captures the universe of emergency procedures. However, the Workgroup also recognized a distinction between emergency services that are performed in the emergency department and major surgical services that go to the operating room.

The Emergent Procedures Workgroup met on July 16, 2015 via conference call and discussed 55 codes identified in the data as being emergent procedures greater than 50% of the time. The Workgroup determined that the specialty societies will need to provide input regarding the appropriate pre-service clinical staff time for the identified emergent services. The Workgroup also noted that in the CMS proposed rule for 2016 released prior to the Workgroup conference call, CMS discussed the recommendation that the RUC made at the January 2015 RUC meeting regarding the Penile Trauma Repair services. This RUC recommendation was the reason for the Emergent Procedures Workgroup to be formed. In the CMS proposed rule for 2016, CMS stated the following:

"Because CPT codes 5443A and 5443B are typically performed on an emergency basis, we question the appropriateness of the standard 60 minutes of pre-service clinical labor in the facility setting, as the typical procedure would not make use of office-based clinical labor. For example, we do not believe that the typical case would require 8 minutes to schedule space in the facility for an emergency procedure, or 20 minutes to obtain consent. We are seeking further public comment on this issue from the RUC and other stakeholders."

The Workgroup discussed the proposed rule. The Workgroup agrees that it is appropriate to reevaluate the time and determine if a new standard is warranted. Two members of the Workgroup articulated potential pre-service tasks for emergent major surgical services. The Workgroup agreed that the standard description of clinical activities might not apply to emergent services and that the activities may look very different than what is currently listed as the standard clinical staff activities. In addition items that are currently allocated time in the pre-service time period may take place in either the service period or in the post-service period for this subset of codes. The PE Subcommittee may need to examine the full set of PE inputs for several of these services, if additional time is warranted in the post-service period.

The Workgroup met on August 31, 2015 via conference call to discuss the response from specialty societies. The Workgroup heard a brief overview of the rationales submitted by AANS/CNS; ACS, SVS, SAGES; AAOS and AUA. The specialties questioned the assumptions used in compiling the data, for example they explained that through this methodology the appendectomy codes are considered emergent and even though the patient presents to the emergency department and has surgery on the same day, there is typically 9 hours of time between these two events, sufficient time of the office clinical staff to perform the pre-service activities. In addition, the Workgroup noted that when the pre-service time standards were developed for 090 day global in 2001 the time was considered an aggregate number of minutes that could be applied broadly with the understanding that some services would realistically

require more pre-service time and some would require less. There was an opportunity for specialty societies to bring forward codes that were outliers and required pre-service time different from the standard 60 minutes; however the only outliers identified at that time were services that required more than 60 minutes of pre-service clinical staff time.

After robust discussion of the information presented by the specialties, the Workgroup determined that they are unable to reach consensus and recommend a standard pre-service time package for emergent 90 day globals in the facility setting. They did however recommend further action for all 55 services and provided those recommendations to the PE Subcommittee for review at the October 2015 RUC meeting.

The PE Subcommittee discussed the work and subsequent recommendations of the Emergent Procedures Workgroup. The PE Subcommittee noted that the methodology developed to identify emergent procedures is a valuable tool and can be used moving forward to identify emergent services in much the same way that services typically billed together are identified for each RUC meeting currently.

The PE Subcommittee first discussed the following list of 2 000 day globals and 4 010 day globals with a dominant specialty of emergency medicine. **The Workgroup recommended and the PE Subcommittee agreed that the pre-service clinical staff time for the following 6 codes be reduced to 0 minutes, as is standard for 000 and 010 day globals.**

43760	Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance	000
65220	Removal of foreign body, external eye; corneal, without slit lamp	000
12055	Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 12.6 cm to 20.0 cm	010
40830	Closure of laceration, vestibule of mouth; 2.5 cm or less	010
41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior two-thirds of tongue	010
41800	Drainage of abscess, cyst, hematoma from dentoalveolar structures	010

The PE Subcommittee then discussed the following list of 14 90 day globals and 1 000 day global with various dominant specialties. The Workgroup recommended that these services be referred to the PE Subcommittee for review of pre-service clinical staff time only at the January 2016 RUC meeting. The Workgroup had discussed that there is work being done for these services that would typically be considered pre-service activities performed by clinical staff that may happen after the surgery is complete or by the physician because it is an emergency situation. The PE Subcommittee determined that this is valid work that does happen and should be recognized. However, if it is typically done post-operatively for these services it would need to be represented in the post-service portion of the practice expense. The specialties are welcome to bring up those concerns in their presentation to the PE Subcommittee in January, however it would mean that the review would be of all the direct practice expense inputs and not limited to the pre-service clinical staff time. Similarly if the specialty wants to make the case that in an emergency situation the physician is performed tasks that clinical staff normally would, the code would have to be reviewed for both work and practice expense. In their presentation to the Subcommittee the specialty societies may choose to include any concern that the service is an anomaly that needs to be flagged as not to be used for comparison in the RUC database. The specialties should also be prepared to discuss any concerns they have about the accuracy of the claims data and whether or not the service is accurately identified as emergent.

The Workgroup recommended and the PE Subcommittee agreed that the specialties develop practice expense pre-service clinical staff time recommendations for the January 2016 RUC meeting for the following 15 codes.

27253	Open treatment of hip dislocation, traumatic, without internal fixation	090
27602	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)	090
35082	Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for ruptured aneurysm, abdominal aorta	090
35207	Repair blood vessel, direct; hand, finger	090
43840	Gastrorrhaphy, suture of perforated duodenal or gastric ulcer, wound, or injury	090
44950	Appendectomy;	090
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis	090
44970	Laparoscopy, surgical, appendectomy	090
49553	Repair initial femoral hernia, any age; incarcerated or strangulated	090
61313	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; intracerebral	090
61315	Craniectomy or craniotomy for evacuation of hematoma, infratentorial; intracerebellar	090
63744	Replacement, irrigation or revision of lumbosubarachnoid shunt	090
54220	Irrigation of corpora cavernosa for priapism	000
54437	Repair of traumatic corporeal tear(s)	090
54438	Replantation, penis, complete amputation including urethral repair	090

Next, the PE Subcommittee discussed the following two groups of codes. The first list is 13 090 day globals and 1 010 day globals with a dominant specialty of emergency medicine and the second list is 20 090 day globals with a dominant specialty of orthopedic surgery. All except one of the codes are closed treatment services. The Workgroup recommended dividing these services and referring the first 14 codes to the Relativity Assessment Workgroup (RAW) and the second 20 to be reviewed for pre-service clinical staff time by the PE Subcommittee at the January 2016 RUC meeting. The PE Subcommittee discussed this recommendation and determined that the vast majority of these codes are part of the same family and it is not possible to divide the family of services based only on the dominant provider. The PE Subcommittee determined that both sets of codes will be referred to the RAW as potentially misvalued. The referral of all the related codes will be useful in determining the appropriate family of services and any other issues that pertain to the closed treatment codes. **The PE Subcommittee recommends that the following 34 codes be referred to the RAW as potentially misvalued. The PE Subcommittee requests that the RAW review the services to determine the site of service and appropriateness of the dominant specialty.**

dominant specialty of emergency medicine

21820	Closed treatment of sternum fracture	090
23650	Closed treatment of shoulder dislocation, with manipulation; without anesthesia	090
24600	Treatment of closed elbow dislocation; without anesthesia	090
25675	Closed treatment of distal radioulnar dislocation with manipulation	090
26700	Closed treatment of metacarpophalangeal dislocation, single, with manipulation; without anesthesia	090
26750	Closed treatment of distal phalangeal fracture, finger or thumb; without manipulation, each	090

26755	Closed treatment of distal phalangeal fracture, finger or thumb; with manipulation, each	090
26770	Closed treatment of interphalangeal joint dislocation, single, with manipulation; without anesthesia	090
27265	Closed treatment of post hip arthroplasty dislocation; without anesthesia	090
27762	Closed treatment of medial malleolus fracture; with manipulation, with or without skin or skeletal traction	090
27818	Closed treatment of trimalleolar ankle fracture; with manipulation	090
27840	Closed treatment of ankle dislocation; without anesthesia	090
28660	Closed treatment of interphalangeal joint dislocation; without anesthesia	010

40650	Repair lip, full thickness; vermilion only	090

dominant specialty of orthopedic surgery

23540	Closed treatment of acromioclavicular dislocation; without manipulation	090
23625	Closed treatment of greater humeral tuberosity fracture; with manipulation	090
23655	Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia	090
23665	Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation	090
24505	Closed treatment of humeral shaft fracture; with manipulation, with or without skeletal traction	090
24605	Treatment of closed elbow dislocation; requiring anesthesia	090
25565	Closed treatment of radial and ulnar shaft fractures; with manipulation	090
25605	Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; with manipulation	090
27230	Closed treatment of femoral fracture, proximal end, neck; without manipulation	090
27232	Closed treatment of femoral fracture, proximal end, neck; with manipulation, with or without skeletal traction	090
27240	Closed treatment of intertrochanteric, peritrochanteric, or subtrochanteric femoral fracture; with manipulation, with or without skin or skeletal traction	090
27252	Closed treatment of hip dislocation, traumatic; requiring anesthesia	090
27266	Closed treatment of post hip arthroplasty dislocation; requiring regional or general anesthesia	090
27502	Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction	090
27510	Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation	090
27550	Closed treatment of knee dislocation; without anesthesia	090
27552	Closed treatment of knee dislocation; requiring anesthesia	090
27752	Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation, with or without skeletal traction	090
27810	Closed treatment of bimalleolar ankle fracture (eg, lateral and medial malleoli, or lateral and posterior malleoli or medial and posterior malleoli); with manipulation	090
27825	Closed treatment of fracture of weight bearing articular portion of distal tibia (eg, pilon or tibial plafond), with or without anesthesia; with skeletal traction and/or requiring manipulation	090

III. Vital Signs Workgroup

During discussion of the Physical Therapy Evaluation services the PE Subcommittee began to question what vital signs are appropriate to justify clinical staff time. The current practice expense standard for vital signs is 3 minutes of clinical staff time for 1-3 vitals and 5 minutes of clinical staff time for 4-6 vitals, however this standard was developed a number of years ago and the vital signs that were appropriate at that time may have changed in subsequent years. The PE Subcommittee determined that a Workgroup will be formed to review any historical information regarding the vital signs that were included in the standard when it was developed, retrieve information regarding what CMS outlines as clinical necessary vital signs and update the RUC accepted vital signs that can be used to justify clinical staff time. The Subcommittee notes that if any of the vital signs used in the Physical Therapy Evaluation services are found to be not acceptable to the PE Subcommittee based on current CMS guidelines there is the potential for the clinical staff time to be adjusted retroactively for those services. **The PE Subcommittee will convene a Vital Signs Workgroup to be chaired by Doctor Brill with Doctors Barkley and MacCormack as members to review the issue and present their recommendation to the PE Subcommittee at the January 2016 RUC meeting.**

IV. Practice Expense Spreadsheet Update Workgroup

CMS has expressed increasing discomfort with the variability of PE spreadsheets that results from differences in standards and conventions between specialties and from code to code. The issue of constantly changing clinical staff activity line items creates problems and confusion both at the PE Subcommittee meeting and when the PE recommendations are reviewed by CMS. Specifically, it makes it difficult to apply practice expense clinical staff time policies consistently, input data for breakdown of clinical labor staff time in the CMS practice expense labor time files (and as a result the RUC database) and provided specific line items for the equipment time formula. The Practice Expense Spreadsheet Update Workgroup will examine these issues and develop potential options and solutions. The Subcommittee recognized that there is a unique spreadsheet already developed for imaging, and that there are less formal but still consistent differences in the way that radiation oncology, pathology and other specialties present their direct practice expense inputs in the currently PE spreadsheet. **The PE Subcommittee will convene a Practice Expense Spreadsheet Update Workgroup to be chaired by Doctor Ouzounian with members from the PE Subcommittee, Doctors Neal, McGinty, Brill and Barkley as well as Doctor Phurrough from CMS.**

V. Tab 12 – Abdominal Aorta Ultrasound Screening

The PE Subcommittee raised concerns that the PE Subcommittee recommendation was prepared by specialty societies that are not the dominant provider of this service according to Medicare claims data. The presenters explained that this is likely due to increased use of G code G0389 for a handheld device, which is not the intended use of the CPT code that is currently used as a crosswalk for the G code. The presenters explained and the PE Subcommittee agreed that this is likely an issue of miscoding. **The PE Subcommittee recommends that the specialty work with the AMA to develop a CPT Assistant article to clarify appropriate use of the new CPT code 767X1 that will replace the G code G0389.**

V. Practice Expense Recommendations for CPT 2016 and 2017

Tab	Title	PE Input Changes
4	Percutaneous Biliary Procedures Bundling	Approved April 2015
5	Intracranial Endovascular Intervention	No PE Inputs
6	Reflectance Confocal Microscopy	Approved April 2015
7	Insertion of Interlaminar-Interspinous Process Stability-Distraction-Device	Postponed to January 2016
8	Flexible Laryngoscopy	Modification
9	Partial Exchange Transfusion	No PE Inputs
10	Epidural Injections	Modifications
11	Retinal Detachment Repair	Minor Modifications
12	Abdominal Aorta Ultrasound Screening	Modifications
13	Fluoroscopic Guidance	Minor Modifications
14	Moderate Sedation Services	Modifications
15	Anterior Segment Imaging	Minor Modifications
16	Prostate Biopsy – Pathology	Approved April 2015

AMA/Specialty Society RVS Update Committee **Tab 20**
Research Subcommittee Meeting
October 1, 2015

Members Present: M. Douglas Leahy, MD (Chair), Christopher Senkowski, MD (Vice Chair), Margie Andreae, MD, Allan Anderson, MD, James Blankenship, MD, Robert Dale Blasier, MD, Scott Collins, MD, Verdi DiSesa, MD, Jane Dillon, MD, MBA, Jeffrey Edelstein, MD, Peter Hollmann, MD, Alan Lazaroff, MD, Paul Martin, DO, Stanley W. Stead, MD, MBA, G. Edward Vates, MD, Jane White, PhD, RD, Jennifer Wiler, MD

I. Research Subcommittee June 2, 2015 Conference Call Meeting Report

The Research Subcommittee report from the June 2015 conference call included in Tab 20 of the October 2015 agenda materials was approved without modification. The modified survey instrument, as approved after the June call, will be included with the archived Research Subcommittee materials for this meeting.

II. Overview of Subcommittee Structure & Responsibilities

The Chair provided an overview of the Research Subcommittee structures and responsibilities for New members of the Subcommittee, including:

- A summary of the Subcommittee's charge of development and refinement of RUC methodology
- The responsibility to review proposals pertaining to: Clinical Vignettes, the standard RUC survey template, proposed reference service lists (RSLs), survey sample methodologies and educational materials

III. Review of Specialty Staff Recommendations for Improving the Number of RUC Survey Responses

In June 2015, AMA staff requested informal feedback from the Research Subcommittee regarding what information the Subcommittee would like for AMA staff to collect to prepare for the Subcommittee's October 2015 deliberation regarding how to increase the average number of survey responses. The Subcommittee requested for AMA staff to reach out to specialties societies regarding how to increase the number of survey responses and this questionnaire was circulated to all specialty staff in July.

AMA Staff received 19 responses to this solicitation. A list of featured recommendations that AMA staff thought the Subcommittee should initially review was provided in the Research agenda materials, in addition to the complete responses. AMA staff noted that review of the individual comments is also strongly recommended.

The Subcommittee discussed the recommendations highlighted by AMA staff, other recommendations from the specialty feedback and newly suggested ideas from Subcommittee members. **The Subcommittee highlighted the following areas that they would like to review in greater detail at future RUC meetings:**

- **Survey Sample Methodology:**
  - Several Subcommittee members concurred with the recommendation for the "random" requirement to be softened or redefined. Further discussion of this topic is included under section IV of these meeting minutes.

- **Audio-visual Education:**
  - *Youtube-style video:* Several Subcommittee members noted support for the idea for the RUC to create a standard online presentation video which can be shared with survey respondents. One potential format mentioned was review of a power point slides with narration. A Subcommittee member suggested for the video to possibly work in an example of a mock survey so people can understand what numbers go in what spots so they get a much better idea of how to fill out the survey. Others noted that the video should also be concise.
- **Incentivizing and Motivating Potential Survey Respondents:**
  - *Survey Memo:* Several Subcommittee members concurred that the standard survey memo language should be revised to better explaining why it is so important for the survey respondent to actually take the survey and why it is in their best interest. The memo should be more strongly worded to make it seem more immediate and important.
  - *Survey Respondent Compensation:* Several Subcommittee members noted that the idea of some sort of compensation of survey respondents should be discussed in detail at a future Subcommittee meeting.
- **Evaluation of RUC Online Survey Tool, RUC Survey Instrument and RUC Survey Process in general:**
  - *Representative Sample of Performing Specialties:* One Subcommittee member noted that if certain Specialties opt to not perform surveys but have a sizeable percentage of Medicare utilization that additional efforts should be made to request for that Specialty to participate in the survey process. This would be to try to get a representative sample of all of the top specialties that perform the services. It was also suggest that if a society decides not to conduct a survey themselves, though has a large percentage of the utilization, that the surveying societies could request for the non-surveying society to provide a random sample of their memberships for inclusion in the RUC survey.
  - *Familiarity with Surveyed Service:* One Subcommittee member suggested that the survey instrument should include introductory language stating that the survey respondents should either have experience performing the service or familiarity with the current practice of the service.
  - *Consideration for Mandating Qualtrics:*
    - The Chair noted that RUC leadership has expressed interest in eventually mandating the Online RUC Survey tool (Qualtrics). The Chair stated that part of the Subcommittee's future tasks would be to further vet the survey instrument in general and the Online RUC survey tool.
    - The RUC Advisor from the American College of Surgeons (ACS) noted that overall their society is very supportive of the RUC online survey process using Qualtrics. The ACS advisor noted that the concern that their society had raised pertained to the legal structure so that the ownership of the raw data is better understood. They noted that the AMA has gone a long way to outline the standards for protection, though noted their society's preference that the rules and protections pertaining the ownership of the raw data should be further codified in a written document. The ACS advisor stated their belief that the principles that AMA has outlined in the AMA's memorandum of understanding are very good principles, though requested for the AMA to provide more detailed documentation to define ownership of the raw data.

Note, the April 21, 2014 Memorandum of Understanding from the American Medical Association already addresses the ownership of the raw data. **The document states:** ***"****Each specialty society owns the raw survey data received through the Qualtrics system. No other party (including Qualtrics) acquires any ownership interest in the data. As between the AMA and specialty societies, the AMA will not assert any ownership of the data."* The document is available on the home page of the RUC Collaboration website.

- Subcommittee members and participants in the audience noted that the survey instrument should be further analyzed to assess what sections of the survey instrument that respondents struggle with the most (ie what section of the incomplete surveys abort the survey instrument at most frequently)
- A specialty society staff member in the audience noted that the raw data output of the Qualtrics survey tool is difficult to interpret. AMA staff concurred that this is one area of the RUC Online survey process that requires more attention and noted that the AMA will be working on a large IT project to improve the display of raw Qualtrics data. AMA staff estimated that this project is currently scheduled for completion for the April 2016 RUC survey process.

The Chair, Vice Chair and AMA Staff will schedule detailed review of these highlighted topics and ideas for subsequent Research Subcommittee meetings.

IV. Refinement of Definition for "Random Sample" and "Targeted Sample"

- **Definition of Random Sample and Targeted Sample:**

At the January meeting, the Subcommittee requested for AMA staff to draft definitions for the terms "targeted" and "random" used in the *Research Subcommittee Guidelines and Requirements Document* for the Subcommittee's review at its April 2015 meeting. At the April 2015 RUC meeting, the Research Subcommittee agreed that the draft definitions will need to undergo further Subcommittee review at the October 2015 meeting prior to the Subcommittee makes a recommendation on implementation**.** During the RUC's *Other Business* discussion at the April 2015 RUC meeting, representatives from several specialties recommended for the "random" definition to also allow them to randomly sample from subsets of their society based on subspecialties and certifications of their general membership.

At the October 2015 Research Subcommittee meeting, the Subcommittee had a robust discussion regarding whether certain types of survey samples should no longer require Research Subcommittee review in the future and whether new more terminology should be developed to describe the types of survey sample methodology. Several Subcommittee members concurred that the "random" requirement should be softened or redefined. Several Subcommittee members conveyed their support for the permission of societies to construct a survey sample that is a random subset of certain targeted populations (ie those members of a Specialty society that hold a certain subspecialty certification) without Research Subcommittee approval. It was noted that this could help mitigate survey fatigue and improve the survey response rate and number of survey responses. A new term for this type of survey sample would likely need to be devised.

One Subcommittee member cautioned that, if the Research Subcommittee were to recommend that certain random samples of targeted populations were approved, that there should be certain explicit constraints regarding when a society could use this proposed random sample of a targeted subset methodology without Research Approval. It was also noted that perhaps certain rules should be drafted which prohibit usage of this new proposed sampling methodology (ie if a new subspecialty is created to create a RUC survey targeted sample population, or certain cases when a subspecialty society solely focuses around a certain device). Several members noted their support for the inclusion of some types of constraints in draft language.

The Subcommittee Chair requested for AMA staff to draft updated survey sample terminology and definitions for a survey sampling methodology that would categorize certain targeted groups (ie those members of a society that hold a subspecialty certification) as not requiring Research Subcommittee approval. This methodology could still use a random sampling method of that subset of a specialty society's membership. The Subcommittee would review this draft language electronically prior to the January 2016 RUC meeting.

- **"Do you Do letter":**

At the April 2015 RUC meeting, it was brought to the RUC's attention that some societies first send a "do you do" letter to a random subset of their members asking whether or not the recipient performs the service and if they are willing to take a survey. The survey link is then sent to those that responded yes to the "do you do" letter. In the past, these societies have reported this survey sample methodology as a random sample on the Work Summary of Recommendation form. At the April RUC meeting, several RUC members questioned the validity of classifying these surveys as random and stated that it would seem to be a targeted survey and that Research Subcommittee approval would be needed for a targeted survey. The RUC expressed concerns that although the members selected to receive the "do you do" letter are selected randomly, a self-selection bias is introduced when they are asked if they are willing to participate. If it is determined that a "do you do" letter is a valid method, than the language of that letter should be uniform and approved by the RUC. Currently, there is no RUC policy prohibiting specialties from conducting their surveys in this way. The RUC had referred this issue to the Research Subcommittee to determine whether this method will continue to fall under the definition of a "random sample".

The Subcommittee discussed this issue though was unable to form a consensus on whether this should represent a valid methodology which would not require explicit Research Subcommittee approval. The Chair requested for AMA staff to create a draft "do you do or are you familiar with this procedure" letter for review by the Subcommittee prior to the January 2016 RUC meeting. This issue will be discussed further at or before the January 2016 Research Subcommittee meeting.

V. Research Subcommittee Guidelines and Requirements Document Review

The Subcommittee did not propose any changes to the Research Subcommittee Guidelines and Requirements document.

VI. Other Business

- **Specialty Society Request for Review of Proposed Revisions to Vignettes:**

Radiation Treatment Device (CPT codes 77332-77334; 77470)
American Society for Radiation Oncology

ASTRO submitted a request to the Research Subcommittee to review a revised vignette for CPT codes 77332 *Treatment devices, design and construction; simple (simple block, simple bolus)*, 77333 *Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)*, 77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)* and 77470 *Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)*

77332 *Treatment devices, design and construction; simple (simple block, simple bolus)*

Existing Vignette: *N/A, existing code without vignette in RUC database*

Revised Vignette as Approved by Research Subcommittee: A 74 year-old male presenting with prostate cancer will be treated with radiotherapy ~~**requiring**~~ **with** the use of simple treatment device.

77333 *Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus)*

Existing Vignette: *N/A, existing code without vignette in RUC database*

Revised Vignette as Approved by Research Subcommittee: A 65 year-old female presenting with breast cancer, initially treated with mastectomy, will be treated with post-operative radiation to the chest wall and regional lymph nodes. Fabrication of bolus material is required.

77334 *Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts)*

Existing Vignette: Following clinical planning (77261-77263), simulation (77280-77290), treatment isodose plan (77305-77315), or a 3D plan (77295) or an IMRT plan (77301), a 61-year-old female with stage IIIb (T2N3M0) non-small cell lung cancer will be treated with concurrent chemotherapy and multiple field radiotherapy and presents for design and construction of the custom blocks. The AP custom block lung/mediastinal field is designed and constructed.

Revised Vignette as Approved by Research Subcommittee: A 61-year-old female with ~~**stage IIIb**~~ non-small cell lung cancer presents for design and construction of a customized immobilization device.

77470 *Special treatment procedure (eg, total body irradiation, hemibody radiation, per oral or endocavitary irradiation)*

Existing Vignette: Following consultation (99240-99245) and clinical treatment planning (77261-77263), it is determined that a 45-year-old female with clinical stage IIA

squamous cell carcinoma of the cervix will be treated with a combination of external beam radiation therapy (EBRT) and brachytherapy.

Revised Vignette as Approved by Research Subcommittee: A 68-year-old male with stage IIIA non- small cell lung cancer will be treated with chemo/radiotherapy preoperatively.

The Research Subcommittee approved the vignettes for 77333 and 77470 without modification and approved the vignettes for 77332 and 77334 with minor modifications as listed above.

AMA
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Memo to: RUC Participants

From: Sherry L. Smith, MS, CPA, AMA Director Physician Payment Policy and Systems SLS

Date: April 21, 2014

Subject: RUC Survey Data Protocols

CONFIDENTIAL

The AMA's RUC staff have received inquiries regarding automation and centralization of the RUC survey process. With assistance from the AMA's Office of General Counsel, we outline below the protocols for use of the Qualtrics.com ("Qualtrics") survey platform and access to RUC survey data. In addition to the protocols outlined below, the survey data are subject to strict confidentiality and data security protections established by the AMA in its contract with Qualtrics, the AMA's contracted online survey services vendor (also summarized below).

- A specialty society that surveys codes for presentation to the RUC will receive a single-user, password-protected account through the AMA's Qualtrics account, without charge to the society (AMA is responsible for fees).
- Each specialty society owns the raw survey data received through the Qualtrics system. No other party (including Qualtrics) acquires any ownership interest in the data. As between the AMA and specialty societies, the AMA will not assert any ownership of the data.
- Each specialty society will have access to an online data analysis tool which processes a visual and downloadable summary depiction of the survey data received from that society's respondents. The tool does not store the underlying data. Only the specialty society has access to the downloadable data used in conjunction with the tool.
- All survey data acquired by specialty societies reside on the Qualtrics contracted cloud-based servers. The AMA does not receive and does not house any survey data on AMA-owned or leased servers. RUC staff or Qualtrics staff may access these data only with consent of the appropriate specialty society.
- Specialty societies may, at their discretion, grant temporary, limited and confidential access to AMA RUC staff to assist in the processing of raw data and/or help with the survey itself. This access does not confer on the AMA any data ownership or continuing access rights.
- The standard methodologies approved by the RUC Research Subcommittee for calculating the data will be made available to all RUC participants. In accordance with current RUC practices, specialty societies are permitted to alter the standard methodologies for calculating data only upon written approval by the RUC Research Subcommittee and the RUC, for good cause.

- Specialty society use of the Qualtrics account is limited to administering surveys solely for the purpose of collecting data for CPT codes under review by the RUC using a pre-approved RUC survey template. The AMA/Qualtrics contract prohibits any other use.

- Specialty societies may not alter the AMA-supplied RUC survey template in any substantive manner (e.g., changes to survey template language or the addition/deletion of questions to the template) without the approval of the RUC Research Subcommittee.

- The AMA adheres to the Council of American Survey Research Organizations (CASRO) Code of Standards. All specialty societies are encouraged to do the same.

- Qualtrics is contractually obligated to adhere to industry best practices to secure data from unauthorized access, use or disclosure, using a variety of technical measures and security technologies, including implementation of all security principles in the Qualtrics Security White Paper v3.1 which states:

  > "Qualtrics' most important concern is the protection and reliability of client data. Our servers are protected by high-end firewall systems, and vulnerability scans are performed regularly. Complete penetration tests are performed yearly. All services have quick failover points with redundant hardware, and complete backups are performed nightly. Qualtrics uses Transport Layer Security (TLS) encryption (also known as SSLv3.1) for all Internet transmitted data. Surveys may be protected with passwords. Our services are hosted by trusted third party data centers that are SSAE-16 SOC 1 Type II audited. All data at rest are encrypted, and data on deprecated hard drives are destroyed by U.S. DOD methods and delivered to a third-party data destruction service."

  The AMA has the right to audit Qualtrics' compliance with data security requirements.

- Qualtrics must also treat all survey data and any personally identifiable information (e.g. data identifying survey respondents) as confidential information and may not disclose data to third parties except as permitted under the contract.

cc: AMA Office of General Counsel

AMA/Specialty Society RVS Update Committee **Tab 21**
Relativity Assessment Workgroup
October 1, 2015

Members: Doctors David Hitzeman (Chair), Gregory Przybylski (Vice-Chair), Ronald Burd, Jimmy Clark, William Donovan, Walt Larimore, Daniel Nagle, Dee Adams Nikjeh, PhD, CCC-SLP, Scott Oates, Guy Orangio, Marc Raphaelson, Sandra Reed, Samuel Silver, Michael Sutherland, Robert Zwolak.

I. New Technology/New Services Action Plan Review (7 issues, 99 codes)

In September 2005, the RUC began a process of flagging services that represent new technology as the codes were presented to the Committee. The RAW will review codes that were flagged October 2010-April 2011 with three years of available Medicare claims data (2012, 2013 and 2014 data).

The RUC agreed that the "New Technology" designation was intended to identify new services or codes whose use was expected to increase over time, such that as the service becomes more common and its use more diffuse, the actual work involved (time and/or intensity) or practice expenses might conceivably change (i.e., what may have seemed hard when originally valued may seem less hard now that it is more common). The RUC affirmed that codes showing a significant increase of utilization over time or dramatically more utilization than initially predicted by the specialty society would, in general, need to be resurveyed by the predominant specialty or specialties.

The Workgroup reviewed the following new technology/new services and recommends the following:

CPT Code	RAW recommendation
14301-14201	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
15271-15278, 15777	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
21011-28047	Review the data for the melanoma diagnoses within these services and the site of service for these services in 2 years (2017).
29582-29584	Specialty societies develop a CPT Assistant article to specify which bandage application should be reported based on what is being treated and review in 3 years (2018)
37191-37193	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
49652-49655	Remove from list, no demonstrated technology diffusion that impacts work or practice expense.
90867-90869	Review utilization in 3 years (2018) and survey if utilization has increased significantly.

II. CPT Assistant Analysis Action Plan Review (8 issues, 16 codes)

At the January 2015 meeting a Workgroup member requested that the Relativity Assessment Workgroup review the effectiveness of the RUC referrals for specialty societies to develop CPT Assistant articles. AMA staff compiled the list of 38 RUC referrals for development of CPT Assistant articles in which an article was published and one year of Medicare utilization data was available. The Workgroup reviewed these 38 services and related CPT Assistant articles. **The Workgroup requested that the specialty societies submit an action plan for the following codes and the Relativity Assessment Workgroup recommends the following:**

CPT Code	RAW recommendation
13120-13122	Specialty societies should submit another CPT Assistant article to educate providers on the clinical requirements for reporting these services, addressing the performance requirements and typical uses of all the codes in the family, as well as for the intermediate repair codes (12031-12037). Articles should include detailed descriptions of procedures, including how to differentiate between complex and intermediate repairs. Re-review in 2017.
26080	Maintain and remove from screen. This is a low volume service.
50605	Appropriately performed by general surgeons. Remove from screen.
52214-52240	Specialty societies to develop a CPT Assistant article to address cystourethroscopy with fulguration and include the bladder tumor resection codes. Public and private insurers do not follow the same reporting guidance for bladder tumor codes. Medicare advises that the largest size tumor code be reported no matter how many tumors were resected; however, commercial insurers do not follow Medicare's directives and may allow reporting of all tumors resected based on size of each tumor. Review in 2017.
63056	2009 CPT Assistant article was effective. Remove from screen.
69801	No miscoding is occurring. Research evidence indicates that this is the proper procedure to treat hearing loss, therefore slow increase is appropriate. Remove from screen.
73580	Review in 2017 to determine of 2015 CPT changes were effective.
96920-96922	Specialty societies should develop a CPT Assistant article to ensure the codes are being used correctly. The May 2013 article was limited to a question of treating a scar using the laser codes 96920-96922, stating that would not be appropriate, and that 96999, Unlisted special dermatological service or procedure, should be used instead. A comprehensive article, with examples, on the use of the use of the three laser codes is needed. Review again in 2017 after article has taken effect.

III. Flagged Services Action Plan Review (4 issues, 17 codes)

<u>*Lumbar Arthrodesis (22612)*</u>

In February 2010, this service was identified via the Codes Reported Together 75% or More screen and in 2011 through the CMS High Expenditure Procedural Codes screen. In January 2013, the RAW reviewed 3/4 2012 utilization data and same day reporting together combinations to determine if codes 22612, 22630 and new bundled code 22633 are being reported correctly. The Workgroup agreed with specialty societies that the 9 months of utilization data appear to shifting appropriately. The RUC requested that an action plan be submitted to the RAW to review the utilization data in 2 years (Oct 2015) to confirm. *Note: In September 2014, this service was also reviewed via the Pre-Time Analysis screen in which the RUC recommend to maintain work RVU and adjust the times from pre-time package 4 (40/18/15).* **The RAW determined that these services are being reported appropriately and data show that these services are not typically being reported together. The RAW recommends that these services be marked as complete.**

<u>*Shoulder Arthroscopy (29824, 29826, 29827 & 29828)*</u>

In February 2010, these services were identified via the Codes Reported Together 75% or More screen. In April 2010, the RAW deferred review of the group until the RUC reviewed 29826 in September 2010 as part of the Harvard valued service with utilization over 30,000. The Workgroup recommended that the RUC consider that 29826 is reported as a stand-alone procedure less than 1% of the time per Medicare claims data. The specialty also noted that 29826 should not be converted to a ZZZ global period as the service in the non-Medicare population is typically performed as a

stand-alone procedure. Review was deferred until review until after the RUC reviewed 29826 in April 2011. In January 2013, the RAW determined that most codes in this family were recently reviewed and agree with the specialty society to maintain the current values and review in 3 years (October 2015) of utilization for CPT codes 29824 and 29827 to determine if further review of these related codes are being commonly billed with each other (2011 utilization data shows these two codes are billed together less than 50% of the time). The RAW requested that the specialty societies should submit an action plan to address reporting of these services. **The RAW reviewed the data and determined that these services are typically not reported together. The RAW recommends that these services be marked as complete.**

*Radiation Treatment (*55875, 77332, 77333, 77334, 77318, 77778 &77790)

During the April 2015, review of interstitial radiation source codes 77778 and 77790, the RUC requested that the RAW review the percentages in which code 55875, 77332, 77333, 77334 and 77318 are reported on the same patient, on the same day, but by different providers with 77778 and 77790, to determine if there is any duplication of work. The specialty society agreed to clarify at RAW the work processes for treatment of prostate cancer with interstitial radiation and explain what work is performed by which provider. The specialty will also clarify when the work is performed, and when it is reported. **The RAW reviewed the descriptions of work for the urologist and radiation oncologists and determined that there is not duplicative work. The urologists inserts the needle and the radiation oncologist removes the needled while dropping seeds.**

Physician Recertification/ Home Healthcare Supervision/Annual Wellness Visit (G0179, G0180, G0181, G0438 & G0439)

In April 2013, these services were identified via the CMS/Other source codes. The Workgroup requested that the specialty societies submit an action plan for the January 2014 meeting. The Workgroup noted that G codes are developed for programmatic need and/or to address statutory requirements. The Workgroup noted that some of the G codes have Medicare utilization well over 1 million. The Workgroup reviewed all 10 G codes. The Workgroup recommended the following services be referred to CPT to possibly develop CPT Category I codes to define these services: G0101, G0179, G0180, G0181, G0283, G0438 and G0439.

AAFP and ACP submitted a letter indicating that creating Category I codes are not necessary as the G codes are working as intended and the creation of Category I codes would cause redundancy and overlap. The RAW should review this letter and determine if these codes should remain as referred to CPT to create a Category I code so a temporary G code may no longer be necessary.

The RAW reviewed the action plan for G0179-G0181, G0438 and G04389 and determined that the RAW should review the previous 10 G-code recommendations from the CMS/Other screen and determine the status of these codes in the CPT process. The Workgroup will review the analysis of these 10 codes and discuss the issue a the January 2016 meeting.

IV. Reiteration of Screens

Site of Service (3 codes)

AMA Staff reviewed services with anomalous sites of service when compared to Medicare utilization data. Three services were identified in which the Medicare data from 2011-2013 indicated that it was performed less than 50% of the time in the inpatient setting, yet include inpatient hospital Evaluation and Management services within the global period. **CPT codes 19303, 52601 and 57240 will be placed on the next Level of Interest form for survey.**

Harvard Valued – Medicare Utilization Over 30,000 (7 codes)
AMA Staff re-ran the Harvard valued codes with utilization over 30,000, based on 2014 Medicare claims data, and identified seven services. **CPT codes 10040, 27370, 30140, 31645, 36215, 64418 and 92140 will be placed on the next Level of Interest form for survey.**

CMS/Other Source (1 code)
AMA Staff re-ran the CMS/Other source codes with 2014 Medicare utilization of 250,000 or more and identified one service. **CPT code 71101 will be placed on the next Level of Interest form for survey. The Workgroup recommends that it lower the threshold and analyze CMS/Other source codes with utilization from 100,000 or more at the January 2016 meeting.**

High Volume (23 codes)
AMA Staff assembled a list of all services with total Medicare utilization of 10,000 or more that have increased by at least 100% from 2008 through 2013. The query resulted in the identification of 23 services. **The Relativity Assessment Workgroup reviewed these services and recommends the following:**

CPT Code	RAW Recommendation
17250	Submit action plan for January 2016 explaining high volume growth.
23472	Remove from screen
27370	Submit action plan for January 2016 explaining high volume growth.
29445	Submit action plan for January 2016 explaining high volume growth.
35475	Remove. CCP at October 2015 CPT meeting to address.
35476	Remove. CCP at October 2015 CPT meeting to address.
67028	Submit action plan for January 2016 explaining high volume growth.
73580	Review in 2017 to determine if CPT 2015 change were effective.
76942	Scheduled to review at 2017 Relativity Assessment Workgroup meeting.
77002	Remove, on this RUC agenda.
77014	Submit action plan for January 2016 explaining high volume growth.
92270	Scheduled to review utilization at Sept 2017 Relativity Assessment meeting.
92507	Submit action plan for January 2016 explaining high volume growth.
95831	Submit action plan for January 2016 explaining high volume growth.
95930	Submit action plan for January 2016 explaining high volume growth.
95970	Submit action plan for January 2016 explaining high volume growth.
96102	Submit action plan for January 2016 explaining high volume growth.
96920	Recommended a CPT Assistant article (see above CPT Assistant Analysis review) and review again in 2017.
96921	Recommended a CPT Assistant article (see above CPT Assistant Analysis review) and review again in 2017.
97532	Submit action plan for January 2016 explaining high volume growth.
97597	Review in 2 years (Sept 2017).
97598	Review in 2 years (Sept 2017).
G0250	Submit action plan for January 2016 explaining high volume growth.

High Level E/M in Global Period (9 codes)
A RUC member requested AMA Staff to query all services with Medicare utilization greater than 10,000 that have a level 4 (99214) or level 5 (99215) office visit included in the global period. There were no codes with volume greater than 10,000 that had level 5 visits. Nine services were identified that have a level 4 office visit. **The Relativity Assessment Workgroup reviewed the data and determined that an action plan to justify the 99214 office visit and review if the family of services also have a level 4 visit for the following codes: 15732, 15734, 19303, 44143, 64561, 64581, and 77427. The Workgroup noted that this screen will be complete after these codes are reviewed as the RUC has more rigorously questioned level 4 office visits within a global period in recent years and will going forward.**

V. Informational Items

The following documents were filed as informational items: Referrals to the CPT Editorial Panel; Referrals to the CPT Assistant Editorial Board; Potentially Misvalued Services Progress Report and CMS/Relativity Assessment Status Report.

AMA/Specialty Society RVS Update Committee **Tab 22**
MPC Workgroup Meeting
October 2, 2015

Members Present: Geraldine McGinty, MD (Chair); Verdi DiSesa, MD (Vice Chair); Thomas P Cooper, MD; Charles Fitzpatrick, OD; John Lanza, MD; Paul Pessis, AuD; Joseph Schlect, MD; M. Eugene Sherman, MD; Samuel Silver, MD; Norman Smith, MD; James Waldorf, MD

I. Review Workgroup Charge/Restructuring of MPC List

The Workgroup members reviewed the Workgroup charge to maintain the list of codes, which is used to compare relativity of codes under review to existing relative values. Evaluate the existing MPC list for codes with accurate intensity (IWPUT) magnitude in collaboration with specialty society input; seek additional codes with similar accuracy from the Medicare Physician Payment Schedule.

The Workgroup also briefly reviewed the restructuring of the MPC list that occurred in 2011.

II. Review/Discuss Improvements to Relativity within MPC List

As part of the Workgroup's charge to evaluate the existing list to assess the accuracy of intensity magnitude across specialty codes, the members reviewed the list of MPC codes ordered by IWPUT. The members agreed that having the specialty societies review the current list, with an eye towards accurate intensity measurements would be beneficial. It was noted that while IWPUT is a useful tool, any additions resulting from this review must still meet the absolute criteria and undergo review by the MPC Workgroup. The members also discussed that the solicitation should also include a reminder for specialties to review their codes that may no longer be appropriate for the list (e.g. recent RUC review and/or CPT modifications).

III. Further Business/Consideration of Future Analysis

The Workgroup considered the large amount of work that the specialties have for the January 2016 meeting and agreed that the solicitation should go out for workgroup review at either the April or October 2016 meetings.

AMA/Specialty Society RVS Update Committee **Tab 23**
CPT Editorial Panel
Emerging CPT/RUC Issues Workgroup
Friday, October 2, 8:00 am – 9:00 am

Workgroup Members in Attendance:
Marc Raphaelson, MD (Chair), Jennifer Wiler, MD (Vice Chair), Sherry Barron-Seabrook, MD, Al Bothe, MD, Daniel E. Buffington, PharmD, MBS, Gregory DeMeo, MD, Mary Foto, OTR, Emily Hill, PA-C, Peter Hollmann, MD, Kathy Krol, MD, M. Douglas Leahy, MD, Jeremy S. Musher, MD, Christopher Senkowski, MD, Edward Vates, MD, Robert Zorowitz, MD

Review and Approval of September 2, 2015 Conference Call

The summary of the September 2, 2015 conference call was approved without revision.

Review of RUC Comment Letter and Currently Available CPT Codes

AMA staff summarized the RUC comment letter (available on RUC collaboration site) and discussed a September 24 meeting between the Ken Brin, MD, Chair of the CPT Editorial Panel, and Peter Smith, Chair of the RUC, and CMS leadership. The Chairmen articulated that the RUC has recommended immediate implementation of existing care management/collaboration services and established this Emerging Issues Workgroup to discuss potential coding proposals related to care coordination and care collaboration. Doctor Peter Hollmann summarized the existing CPT codes for care management/collaboration services as listed in the RUC comment letter.

Review of Specialty Society Comments and Discussion of New Coding/Valuation Opportunities

Comments were provided from several specialty societies and AMA staff collated these comments into the attached grid. Several of the representatives summarized these comments verbally during the meeting.

General Discussion

The Workgroup convened a general discussion regarding next steps and general concepts and concerns related to future work:

- Doctor David Hitzeman summarized the RUC's work on the development of resource costs for Medical Home (see www.ama-assn.org/go/medicalhome). Ms. Smith shared that CMS mentioned this work in the September 24 leadership meeting and there may be an opportunity for further work to reexamine this work product. This work may serve as a model for other potential Advanced Payment Models that would not be paid on the Medicare Physician Payment Schedule.

- Several members of the Workgroup acknowledged the importance of involvement of physicians from all specialties and other health care professionals in developing proposals. Care management is provided by many specialties and other health care professionals are important team members in the provision of care collaboration.

- Data will be important in the consideration of additional codes or to utilize in persuading CMS to pay separately for existing services. For example, physician experience with the newly implemented CCM code.

- Collaboration between the CPT Editorial Panel and the RUC will be critical as new CPT codes for care management/collaboration and advanced payment models are developed. A process for conducting a preliminary review of specialty code proposals should be discussed in the future. The Workgroup will meet at the CPT Editorial Panel meeting on Friday, October 9, 2015 at 4pm eastern and further discussion may be anticipated at this meeting.

- A general concern was raised that it will be important not to describe work and resource costs that would be duplicative to codes already described in CPT.

- A member noted that for a given condition, a single prescriptive code may not be adequate for all practice settings. Instead, specialties might consider a menu of codes for same condition/stage of disorder, one of which may be applied in any given practice setting.

Care Management and Care Collaboration
Specialty Society Comments to CMS – New Code Suggestions
September 2015

Society	New Code Suggestions
American Association of Clinical Endocrinologists	Code reported on a monthly basis to serve as a "coach" to the primary care team responsible for a patient with uncontrolled diabetes (for example) to include a care plan and ongoing telephone and online consultations. Disease specific transitional care management (TCM) and complex chronic care management (CCM) codes.
American Academy of Family Physicians	Prefers review and refinement Evaluation and Management (E/M) codes over the addition of "add-on" codes to current E/M services. E/M guidelines should also be re-visited. If CMS finalizes plan to create add-on codes, AAFP argues that the current non face-to-face services described in CPT should be implemented for separate payment. Support for collaborative care codes for patients with common behavioral health conditions and plans to work with the American Psychiatric Association.
American Academy of Neurology	Supports add-on codes that require at least 20 minutes of clinical staff time and describe: • Comprehensive care plan • Medication reconciliation • Oversight of patient self-management of medications • Manage care transitions • Coordinate care with home and community-based providers Supports the addition of a code, similar to 90875, to describe interactive complexity in E/M codes. Proposes that codes for physician services requiring at least 20 minutes of time, but not requiring a face-to-face visit be developed for: • Physician review and interpretation of validated questionnaires • Physician review, interpretation and discussion of lab results and/or imaging studies
American Association of Neurological Surgeons/Congress of Neurological Surgeons	New codes to describe the consultative role of a specialist should be created to describe the work between the primary care physician and the specialist to collaborate care. Example: A patient with back pain who is a candidate for spinal surgery, but where other issues (obesity, diabetes control, and smoking cessation) must first be addressed.
American Academy of Otolaryngology-Head and Neck Surgery	Supports codes to describe collaborative care. Raises issue of previous consultation codes. Example of care collaboration: head and neck cancer patients who require oncologic coordination and tumor boards.

Society	New Code Suggestions
American College of Allergy, Asthma and Immunology	Supports a code and payment for CCM of a patient with ONE chronic condition. Recommends an add-on code to E/M to describe a patient requiring a more intense level of care.
American College of Cardiology	Suggests that add-on codes to E/M should describe patients requiring additional resources (eg, advanced heart failure, rhythm disorders, cardio-oncology, resistant hypertension, etc). The add-on codes could be similar in nature to CPT code 90875, describing interactive complexity in psychotherapy services.
American College of Physicians	ACP supports a code bundle for Diabetic care management. Coverage is also encouraged for evidence-based lifestyle modification programs. Support for a code to describe e-consultations between hospitalists and primary care physicians and specialists and primary care physicians. Support for codes to describe the collaborative care model for behavioral health. Suggests that the Center for Medicare and Medicaid Innovation (CMMI) engage in a demonstration project that could be rapidly expanded within Medicare. Encourage add-on codes to CCM code to allow for time increments greater than 20 minutes of clinical staff time.
American College of Surgeons	Support payment for the professional work of care management and collaborative care services, for both primary care and surgeons. Provides examples, such as a breast cancer patient requiring coordination with radiologists, oncologists, plastic and reconstructive surgeons, primary care physicians and physical therapists. Mutli-disciplinary tumor boards may be a component of care collaboration. Another example provided was trauma patients. The trauma surgeons works with anesthesiologists, other surgical specialties, physical therapists, occupational therapists, speech pathologists, psychologists, dieticians, and others. Trauma surgeons must often coordinate with the legal system following the care of their patients.
Academy of Nutrition and Dietetics	Encourages CMS to recognize the importance of non-physician health professionals in the care management of patients. Suggests an addition of an add-on code to be used by non-physicians to capture the care coordination provided to Medicare patients with complex needs. Advocates that obesity should be counted as one of the chronic health conditions requiring care management services.
American Psychological Association	Supports the consideration of a collaborative care model for treating Medicare patients with common behavioral health conditions. Requests that psychologists be consulted and included in the development of codes and models to be considered by CMS.

Society	New Code Suggestions
American Psychiatric Association	APA recommends two codes to describe the services provided under the collaborative care model for beneficiaries with common behavioral health conditions. A care management code would include the functions of a care manager such as patient education; outcomes tracking; coordination of care with the primary care and psychiatric consultant; etc. A second code would describe the consultation services provided to the primary care practice by the psychiatric consultant, including weekly review of patients treated in primary care who are not improving, diagnostic and/or treatment recommendations to the primary care team, and availability for consultations to primary care physicians during work hours.
American Society of Clinical Oncology	Encourages new codes for "planning and thinking critically about the individual chronic care needs of particular subsets of Medicare beneficiaries." ASCO describe treatment planning, monitoring, and identification of appropriate clinical trials for individual patients as work that oncologists are currently unable to code or receive payment.
Renal Physicians Association	Supports new codes for collaborative care activities to be billed in conjunction with the monthly ESRD codes. RPA states that nephrologists should be allowed to bill for non-ESRD services when they are coordinated their patients overall healthcare needs.

Multi-specialty letter coordinated by the American Geriatrics Society:
American College of Allergy, Asthma and Immunology;
American Academy of Home Care Medicine;
American Academy of Hospice and Palliative Medicine;
American Academy of Neurology;
American College of Rheumatology;
American Gastroenterological Association;
American Psychiatric Association
American Society for Blood and Marrow Transplantation;
Infectious Diseases Society of America
	The sign-on letter called on CMS to:
	
	• Establish guidelines for creation of new codes for professional work and collaborative care to assist stakeholders in making recommendations;
	• Establish codes and separate payment for the following services
	    • Collaborative care
	    • Patients with acute illness or on a course of chemo- or immunotherapy
	    • Interactive complexity
	    • Medication therapy management and genetic counseling services
	• Establish codes for separate payment for collaborate care models for beneficiaries with common behavioral health conditions
	• Make separate payment for existing CPT codes that describe care coordination and care collaboration

AMA/Specialty Society RVS Update Committee **Tab 24**
PLI Workgroup Meeting
October 2, 2015

Members Present: Margaret Neal (Chair), MD; Jane Dillon, MD; James Gajewski, MD; Michael Gerardi, MD FACEP; Paul Martin, DO, FACOFP; Daniel Nagle, MD; Sandra Reed, MD; Michael Sutherland, MD, FACS; and Doris Tomer

I. Review Workgroup Charge

The Workgroup members reviewed the workgroup charge to review and suggest refinements to Medicare's PLI relative value methodology.

II. Summary of Recent CMS Decisions on PLI RVUs/RUC Comments

AMA staff reviewed several of CMS's proposals for CY 2016.

- CMS proposed to begin conducting annual PLI RVU updates to reflect changes in the mix of practitioners providing services, and to adjust PLI RVUs for risk. This is an issue the PLI Workgroup originally identified and submitted to the Agency in the Final Rule comment for 2015.
- For low volume codes, CMS proposed to modify the specialty mix assignment methodology to use an average of the three most recent years of available data instead of a single year of data, as is the current policy. The RUC/PLI Workgroup supports this proposal.
- CMS proposed to allow add-on codes to have 0.00 PLI RVUs because of the risk associated with the base procedure. While this affects very few add-on services, the RUC comments ask CMS to reverse this decision.

The Workgroup members agreed that the RUC should continue to press CMS to collect PLI premium data more frequently than every five years.

III. Review of PLI Crosswalk Information on SORs

AMA staff noted that an often overlooked portion of the SOR form is the PLI crosswalk information. When a new code is reviewed, CMS must assign a PLI RVU based on a crosswalk to an existing code. Since the primary criterion for establishing a PLI RVU is the specialty utilization mix, an existing code that contains the same anticipated utilization for the new code should be used, regardless of work RVU.

The members discussed potential options for the PLI crosswalk information on the SOR to be more prominent. One idea is to move the crosswalk information above the additional rationale section of the SOR, so that the information isn't overlooked. Also, the members discussed whether or not it was worthwhile having the utilization mix for the existing PLI crosswalk code listed explicitly on the SOR. The members agreed that the cost benefit of this change would not be worth it.

IV. Further Business

The Workgroup will meet again following any forthcoming CMS proposals that require Workgroup attention. Additionally, the consequences of the Agency's proposal to consider three years of data for low volume codes will be review and specialty societies will be informed about the impact.

AMA/Specialty Society RVS Update Committee **Tab 25**
Joint CPT/RUC Moderate Sedation Workgroup Report
October 2, 2015

Workgroup Members Present: Albert Bothe, MD (Co-Chair) W. Bryan Sims, DNP (Co-Chair),Amr Abouleish, MD, Michael Bishop, MD, James Blankenship, MD, Kathy Krol, MD, Guy Orangio, MD, Steve Peters, MD, James Waldorf, MD and Richard Whitten, MD

I. Review and Discussion of Moderate Sedation Services Valuation (Tab 14)

The Workgroup and RUC Reviewers discussed the specialty society recommendations for Moderate Sedation codes 991X1-991X6 and provided the presenting societies with feedback pertaining to which recommendations the societies may want to consider amending. The surveying societies for codes 991X3X, 991X4X and 991X6X indicated that they would be submitting updates recommendations to the RUC.

II. Review Predicted Utilization

The Workgroup discussed how to handle the unbundling of moderate sedation services from the codes in Appendix G regarding physician work. The standard practice expense inputs will be removed. AMA staff prepared an analysis for the Workgroup to consider. This option incorporates input from the specialties. The proposal is to back out a two-tier budget neutral work RVU from Appendix G codes (excluding add-on codes) based on whether the code has RUC pre-service time package 1B (5 minutes of Moderate Sedation time) or pre-service time package 2B (10 minutes of Moderate Sedation time). For services that do not have RUC-assigned pre-time packages, the analysis used the placeholder pre-time packages assigned by the top performing specialties and approved by the RUC at the April 2015 RUC meeting. The output of the analysis is budget neutral and based on a hypothetical input of 0.25 work RVUs for code 991X2X. The spreadsheet is dynamic so the work RVU input can be changed to calculate other hypothetical results. Based on the value of 0.25 work RVUs, 0.09 would be removed from all Appendix G codes with pre-time package of 1B and 0.18 would be removed from all Appendix G codes with pre-time package 2B.

AMA Staff provided an overview of this spreadsheet and answered several questions. The spreadsheet, titled *05 Projected Medicare Utilization for Moderate Sedation Code 991X2X*, can be found in tab 25 of the agenda materials. **The Workgroup agreed that this proposed methodology is appropriate and recommends that the full RUC consider adopting this methodology.**

AMA/Specialty Society RVS Update Committee **Tab 26**
Surgical Global Workgroup Meeting
October 2, 2015

Members Present: George Williams, MD (Chair); Walt Larimore, MD (Vice Chair); Allan Anderson, MD; Robert Dale Blasier, MD; William Donovan, MD; David Hitzeman, DO; Mollie MacCormack, MD; Christopher Senkowski, MD, FACS; Matthew Sideman, MD; Holly Stanley, MD; Timothy Tillo, DPM

I. Review Workgroup Charge

The Workgroup members reviewed the Workgroup charge: to examine CMS proposal to collect data on services performed within the surgical global post-operative period. Develop improvements in the RUC review process to ensure confidence in the post-operative visit data. Examine the current Qualtrics survey tool in collaboration with the Research Subcommittee and recommend enhancements/changes to improve veracity of collected visit data.

II. Review RUC Comments from 2016 NPRM

The Workgroup members reviewed the most recent RUC comments related to the surgical global issue and noted that the comments are largely the same as before. CMS did not provide any concrete proposals to collect post-operative visit data, as they are statutorily required to, by 2017.

III. Review Current Qualtrics Survey Post-op Visit Collection

AMA staff provided a quick tutorial of how the post-operative visits are currently collected on 010 and 090 global codes using the Qualtrics survey tool. The members discussed whether or not it would be beneficial to collect more information related to the level of visit provided on the same day, if applicable. This can be further discussed with the Research Subcommittee

IV. Review/Discuss Alternate Ways to Collect Post-op Visit Data

The members discussed the current use of 99024 as an option to collect post-operative visits. Most EMRs are requiring the use of 99024 for post-operative E/M services. This data should be available for any user of large EMRs (e.g. EPIC) not just the large institutions like Mayo and Geisinger. However this information isn't being collected in the hospital and doesn't specify the level of visit. Additionally, these large EMR companies have not previously been willing to share this data with outside stakeholders.

Additional proposals discussed included the potential for new codes to be created for tracking visits in the hospital. These codes could also address the different practice expense inputs that are inherent to E/M done in the post-operative period compared to stand alone E/M.

Finally, several members discussed the potential changing nature of post-operative work, specifically, the use of hospitalists in the care of patients. If practice patterns are indeed changing, and moving towards the typical encounter, the shifting of work from the operating physician to the hospitalist should be addressed. To monitor these shifts, data registries could be queried as well as a specific AMA survey could be conducted.

V. Further Business

The Workgroup will review the CMS final decisions in the 2016 Final Rule related to the collection of post-operative visits and convene a meeting to discuss.

Members Present: Scott Collins, MD (Chair), Stan Stead, MD (Vice Chair), Gregory L. Barkley, MD, Michael Bishop, MD, James Blankenship, MD, Ronald Burd, MD, Joseph Cleveland, MD, Alan Lazaroff, MD, Charles Mabry, MD, Scott Oates, MD

I. Overview of Workgroup Structure and Responsibilities

The Chair gave a brief overview of the newly formed workgroup and its responsibilities. The Workgroups charge is to identify sources of extant time data and review alternative/additional measures of intensity. Catalog existing RUC methods to determine intensity, verify their applicability and investigate and develop new methods to determine intensity magnitude. In the short-term, the Workgroup will also review any CMS proposals related to consultant work (eg, RAND report). The Workgroup will work closely with the Research Subcommittee if any methodological changes are recommended.

II. Potential Topics for Workgroup to Evaluate and Address at future meetings:

- *Current Intensity and Complexity Measures*
- *Past RUC Efforts to Value Intensity Directly*
- *Intra-service Work Per Unit of Time (IWPUT) Usage and Calculation*
- *Time Data*
- *Extant Databases*
- *CMS proposals related to Consultant work (ie RAND and Urban Institute studies)*
- *Discuss Code Families with Identical Times but different intensities:* The Chair requested for AMA staff to catalogue codes with identical intra times/ or total times in the same family but have different intensities (values) for the January meeting.

III. Discussion: Existing RUC Work Intensity Methodologies

One of the charges of the Time-Intensity Workgroup is to catalog existing RUC methods to determine intensity, verify their applicability and investigate and develop new methods to determine intensity magnitude. Once the Time-Intensity Workgroup is interested in reviewing the topic of survey intensity/complexity in detail, AMA staff could conduct analyses comparing the previous intensity/complexity methodology to the current methodology.

The Chair stated how those survey intensity/complexity (I/C) measures are difficult for many RUC members to understand and their utility should be assessed by the Workgroup in the future. Some Workgroup noted that the current I/C measures are not useful to them whereas another member noted that they find the current measures useful once getting beyond the initial learning curve.

An individual asked about the reporting of median vs mean for the intensity measures. AMA staff and audience members provided historical information on why this change had been previously made several years ago, noting for example how the sample size for respondents selecting the top key reference code is relatively low which may make the median calculation less valid. **The Workgroup Chair requested for AMA staff to reach out to several specialties for tabs of the upcoming median and request for them to also calculate the median for their I/C measures, but solely for review by the Time-intensity Workgroup.**

One Workgroup member referenced a historical JAMA paper about the Harvard study included in materials. The article mentioned that Hsiao and his colleagues had observed that mental effort judgement, technical skill/physical effort, and psychological stress may potentially be impossible to objectively observe.

The Vice Chair asked the question regarding would it be more appropriate to continue to refine the current system or should the RUC consider adopting a brand new system? One potential alternate system would be the NASA-TLX work intensity scale. The vice chair noted that the factors of the NASA-TLX (Mental demand, physical demand, temporal demand, performance, effort and frustration) are analogous

to the Intensity and Complexity factors as defined by CMS and the RUC. Another Workgroup member noted that the Hsiao study had mentioned the NASA intensity tool and had partially based their intensity work on that; the member questioned whether the cost/benefit of making such a massive change would be beneficial? Several Workgroup members noted that they would prefer that the RUC tweaks the current process and thinks that completely redoing the process might not be beneficial.

Alternate Intensity Methodologies:
The Workgroup also discussed past alternate RUC methodologies for determining the intensity of physician work. The most commonly used alternate intensity methodologies, other than assignment by expert panel, are the Rasch Analysis of Paired Comparisons and Intensity Magnitude estimation by direct survey. Their future usage currently requires prior authorization by the Research Subcommittee on a case by case basis; they have been used very rarely outside of the five year review process. A Workgroup Member noted that their Specialty society and other societies had previously found this method useful for comparing services within the same specialty, though found that it was not valid for cross-specialty comparison. Regarding the direct intensity survey methodology, it was noted that the Society of Thoracic Surgeons (STS) could be asked at a future date to present information from their experience with using direct intensity surveys during the 5 year review.

IV. Extant Data Sources

One of the charges of the Time-Intensity Workgroup is to identify sources of extant time data. The Workgroup briefly discussed this topic and agreed to discuss this topic in further detail at a future Workgroup meeting.

V. Statistical Analysis of RUC Time Data

The Chair and AMA staff noted that the Workgroup could explore expanding the basic analyses of survey time data or incorporating more advanced statistical measures (ie standard deviation). The Chair and AMA staff will explore what can be done within the RUC Online Survey Process (Qualtrics tool). The Workgroup could weigh whether or not proposed changes should be considered.

VI. Other Business

- There have been no new publicly-available updates from the RAND or Urban Institute studies since the RUC last reviewed their status in early 2015.

AMA/Specialty Society RVS Update Committee **Tab 04**
Percutaneous Biliary Procedures Bundling
Facilitation Committee #1

Members Present: Verdi DiSesa, MD (Chair), Margie Andreae, MD; Amr Abouleish, MD; Michael Bishop, MD; Thomas Cooper, MD; Douglas Leahy, MD; Marc Raphaelson, MD; Christopher Senkowski, MD; Stanley Stead, MD; James Waldorf, MD; George Williams, MD

The Facilitation committee reviewed the concerns of the RUC regarding the first code that failed- CPT code 47531. The concern centered on the reduction in physician time from the current reporting of this procedure (total time= 66 minutes) to the survey total time of 54 minutes. Although the RUC did accept compelling evidence of a change in work for this family of procedures, the facilitation committee members and the RUC, considered that the increase in work RVUs from the current reported codes (aggregate work RVU= 1.18) to the survey 25th (work RVU= 1.50) was too large considering the decrease in physician time. Therefore, the facilitation committee looked for a direct crosswalk to properly value 47531.

The committee members reviewed CPT code 46611 *Anoscopy; with removal of single tumor, polyp, or other lesion by snare technique* (work RVU= 1.30, intra time= 15 minutes). This code has identical intra-service time and offered a reasonable physician work comparison to the surveyed code. To validate a work RVU of 1.30, the committee also reviewed code 36580 *Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access* (work RVU= 1.31, intra time= 15 minutes). **Given both these reference services, the facilitation committee recommends a work RVU of 1.30, with a direct crosswalk to CPT code 46611, for CPT code 47531.**

The committee then reviewed the rest of the family of services and agreed that for all the codes but one (CPT code 47544) the survey 25th percentile work value was appropriate. The specialty societies agreed to revise their previous recommendations for codes that were above the survey 25th percentile down to the survey 25th percentile. For these procedures, the members agreed that the work value rank order was properly preserved at these data points. **The attached table displays the committee recommendations at the 25th percentile work values for CPT codes 47532, 47533, 47534, 47535, 47536, 47537, 47538, 47539, 47540, 47541, 47542 and 47543.**

Finally, the committee reviewed the survey results for CPT code 47544. This procedure code had fewer survey responses, 32, and a lower median performance rate, than the other services reviewed in the family. Thus, the survey results were not considered as strong as most of the other codes in the family. The committee members compared this service to the work difference between the recently approved ERCP base code 43260 (work RVU= 5.95) and the ERCP with destruction of calculi code 43265 (work RVU= 8.03). The resulting work value difference of 2.08 suggested that the survey 25th percentile work value of 3.95 was too high. To find an appropriate value, the committee used two codes as direct crosswalks: CPT code 37185 *Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic*

injection(s); second and all subsequent vessel(s) within the same vascular family (work RVU= 3.28, intra time= 40 minutes) and 92973 *Percutaneous transluminal coronary thrombectomy mechanical* (work RVU= 3.28, intra time= 40 minutes). **The committee recommends a work RVU of 3.28, a direct crosswalk to codes 37185 and 92973, for CPT code 47544.**

CPT Language:
The committee noted that while the CPT introductory language is clear that CPT code 47544 should not be used for removal of incidental sludge and/or debris, the CPT descriptor explicitly includes removal of calculi/debris. A CPT representative in attendance noted that this could pose a problem and may need to be addressed by the CPT Editorial Panel in order to make an editorial change to remove the confusing language for this code (47544).

CPT	Pre Time	Intra Time	Post Time	Recommended work RVU	Physician Work	Rationale
47531	27	15	12	1.30	Contrast injection through existing access	Direct crosswalk to code 46611 *(Lower than survey 25th)*
47532	38	45	15	4.50	New access to bile duct + contrast injection	Survey 25th percentile
47533	41	60	20	5.63	47532 + additional access + drain placement	Survey 25th percentile
47534	41	68	20	7.85	47533 + crossing occlusion + placement of int-ext drain	Survey 25th percentile
47535	33	45	15	4.20	47534 – 47533 + 47536 (drain exchange)	Survey 25th percentile
47536	28	20	13	2.86	47531 + tube exchange	Survey 25th percentile
47537	27	15	10	1.84	47531 + drain removal	Survey 25th percentile
47538	38	53	15	5.00	47534 – drain placement	Survey 25th percentile
47539	41	75	20	9.00	47536 + balloon dilatation (47542) + stent placement	Survey 25th percentile
47540	41	85	20	9.28	47541 + balloon dilatation (47542) + stent placement	Survey 25th percentile
47541	41	60	20	7.00	47534 + balloon dilatation (47542) + stent placement	Survey 25th percentile
47542	-	30	-	2.85	Balloon dilation of biliary duct(s) *(ZZZ add-on)*	Survey 25th percentile
47543	-	30	-	3.00	Endoluminal biopsy(ies) of biliary tree *(ZZZ add-on)*	Survey 25th percentile
47544	-	45	-	3.28	Removal of calculi/debris from biliary duct *(ZZZ add-on)*	Direct crosswalk to codes: 37185 (3.28) / 92973 (3.28) *(Lower than survey 25th)*

Facilitation Committee #2
Fluoroscopic Guidance

Facilitation Committee Members: *Doctors Scott Collins (Chair), James Blankenship, Jane Dillon, Walter Larimore, Alan Lazaroff, Margaret Neal, Gregory Przybylski, and Joseph Schlecht*.

The Facilitation Committee discussed the issues with the physician time recommended for these ZZZ global period services. The Committee noted that the recommendations for the related epidural injection codes with and without fluoroscopic guidance established a difference of 2 additional minutes of pre-service positioning time for the fluoroscopic guidance as the only difference in physician time. After much deliberation on whether additional pre and post-service time are included in these services the Committee determined that it would be difficult to now recommend 7 additional minutes pre-service time and 5 minutes immediate post-service time.

77001 Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)

The Committee reviewed the physician work required to perform this service and recommends maintaining the current work RVU of 0.38 for 77001. The Committee recommends 2 minutes of positioning time, the additional pre-service time as established for the epidural injection with fluoroscopic guidance codes, and 15 minutes intra-service time. The Committee referenced ZZZ-global period CPT code 93320 *Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete* (work RVU = 0.38 and 15 minutes intra-service time) to support the recommended physician work and time recommended for CPT code 77001. **The Committee recommends a work RVU of 0.38 for CPT code 77001.**

77002 Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)

The Committee reviewed the physician work required to perform this service and recommends maintaining the current work RVU of 0.54 for 77002. The Committee recommends 2 minutes of positioning time, the additional pre-service time as established for the epidural injection with fluoroscopic guidance codes, and 15 minutes intra-service time. The Committee referenced ZZZ-global period CPT code 96571 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)* (work RVU = 0.55 and 15 minutes intra-service time) to support the recommended physician work and time recommended for CPT code 77002. **The Committee recommends a work RVU of 0.54 for CPT code 77002.**

77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

The Committee reviewed the physician work required to perform this service and recommends maintaining the current work RVU of 0.60 for 77003. The Committee recommends 2 minutes of positioning time, the additional pre-service time as established for the epidural injection with fluoroscopic guidance codes, and 15 minutes intra-service time. The Committee referenced ZZZ-global period CPT code 96571 *Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes (List separately in addition to code for endoscopy or bronchoscopy procedures of lung and gastrointestinal tract)* (work RVU = 0.55 and 15 minutes intra-service time) to support the recommended physician work and time recommended for CPT code 77003. **The Committee recommends a work RVU of 0.60 for CPT code 77003.**

CPT Code	Pre-Service Positioning	Intra-Service Time	Work RVU Recommendation
77001	2	15	0.38
77002	2	15	0.54
77003	2	15	0.60