AMA/Specialty RVS Update Committee
Meeting Minutes
September 18-20, 2014

I. Welcome and Call to Order

Doctor Barbara Levy called the meeting to order on Friday, September 19, 2014 at 1:00 pm. The following RUC Members were in attendance:

Barbara Levy, MD	Amr Abouleish, MD, MBA*
Margie C. Andreae, MD	Allan A. Anderson, MD*
Michael D. Bishop, MD	Gregory DeMeo, MD*
James Blankenship, MD	Jane Dillon, MD*
Dale Blasier, MD	William D. Donovan, MD, MPH, FACR*
Albert Bothe, MD	Jeffrey Paul Edelstein, MD*
Ronald Burd, MD	Stephen Lahey, MD*
Scott Collins, MD	M. Douglas Leahy, MD, MACP*
Thomas Cooper, MD	Mollie MacCormack, MD*
Anthony Hamm, DC	Paul Martin, DO, FACOFP*
David F. Hitzeman, DO	Eileen Moynihan, MD*
Charles F. Koopmann, Jr., MD	Margaret Neal, MD*
Robert Kossmann, MD	Scott D. Oates, MD*
Walt Larimore, MD	Christopher K. Senkowski, MD, FACS*
Alan Lazaroff, MD	M. Eugene Sherman, MD*
J. Leonard Lichtenfeld, MD	Norman Smith, MD*
Scott Manaker, MD, PhD	Holly Stanley, MD*
William J. Mangold, Jr., MD	Robert J. Stomel, DO*
Geraldine B. McGinty, MD	G. Edward Vates, MD*
Gregory Przybylski, MD	Thomas J. Weida, MD*
Marc Raphaelson, MD	Adam Weinstein, MD*
Sandra Reed, MD	Jane White, PhD, RD, FADA, LDN*
David Regan, MD	Jennifer L. Wiler, MD*
Chad Rubin, MD, FACS	
Joseph Schlecht, DO	
Peter Smith, MD	
Samuel D. Smith, MD	
Stanley W. Stead, MD, MBA	
James C. Waldorf, MD	*Alternate
George Williams, MD	

II. Chair's Report

- Doctor Levy welcomed everyone to the RUC Meeting.
- Doctor Levy welcomed the following Centers for Medicare & Medicaid Services (CMS) staff and representatives attending the meeting:
    - Edith Hambrick, MD – CMS Medical Officer
    - Steve E. Phurrough, MD – CMS Medical Officer
    - Chava Sheffield, PhD - Chava Sheffield, PhD, OTR/L – Health Insurance Specialist (PE methodology, SGR, conscious sedation, conversion factors)

  - Jessica Bruton, MPA – Health Insurance Specialist (physician work and potentially misvalued services)
  - Lan Zhao – Consultant, S3 Consulting Group
- Doctor Levy welcomed the following Contractor Medical Directors:
  - Charles Haley, MD, MS, FACP
- Doctor Levy welcomed:
  - Barbara L. McAneny, MD – AMA Board of Trustees Chair
- Doctor Levy welcomed the following Government Accountability Office (GAO) staff attending the meeting:
  - Greg Giusto, Assistant Director – Health Care
  - Alison Binkowski, Senior Analyst (Analyst-in-Charge) – Health Care
  - Katy Coffey, Senior Analyst – Health Care
  - Marissa Barrera, Analyst – Health Care
- Doctor Levy welcomed the following Researchers from Stanford University:
  - David Chan, MD, PhD
    - Assistant Professor of Medicine, Stanford School of Medicine
  - Michael J. Dickstein, PhD
    - Assistant Professor of Economics
- Doctor Levy welcomed the following Member of the CPT Editorial Panel:
  - Leslie Davidson, MD – Panel Member Observer
- Doctor Levy welcomed new RUC members:
  - Robert Kossmann, MD - Renal Physicians Association
  - Chad Rubin, MD, FACS - American College of Surgeons
  - Joseph Schlecht, DO - Primary Care
- Doctor Levy welcomed new RUC Alternate members:
  - Paul Martin, DO, FACOFP - Primary Care
  - Christopher Senkowski, MD, FACS - American College of Surgeons
  - Adam Weinstein, MD - Renal Physicians Association
- Doctor Levy met with U.S. Congressman Rep. Kevin Brady (R), TX-8, on July 30, 2014. Representative Brady is the Chairman of the Health Subcommittee for the House Ways and Means Committee. Doctor Levy and AMA staff spent over an hour with the Representative and his health policy staff. The representative and his staffer went into a lot of detail about the RUC process and now have a much better understanding of how we do our work and the necessity of the RUC.
- Doctor Levy laid out the following RUC established thresholds for the number of survey responses required:
  - Codes with $\geq$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 Levy 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 Levy laid out the following procedural issues 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 Levy 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 Levy laid out 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
- Please note that all meetings are recorded for AMA staff to accurately summarize recommendations to CMS.

III. Director's Report

Sherry L. Smith, MS, CPA, provided the director's report and indicated:

- The wireless internet code and password.

IV. Approval of Minutes of the April 24-27, 2014 RUC Meeting

The RUC approved the April 2014 RUC Meeting Minutes as submitted.

V. CPT Editorial Panel Update (Informational)

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

- Doctor Bothe thanked Doctor Levy for mentioning the attendance of Doctor Davidson as an observer from the CPT Editorial Panel at this meeting. In a reciprocal fashion, Doctor Raphaelson attended the CPT Editorial Panel Meeting in May. Doctor Larimore and Doctor Byrd are scheduled to attend the next two CPT meetings, but there are still openings further out and CPT would welcome additional visitors.

- The last CPT meeting was relatively light with only 18 tabs that required actions. Among the main issues addressed was a review of the terminology for molecular pathology, updating of the vaccine code language and updating of the category III temporary codes that are not reviewed by the RUC.
- At the last RUC meeting there were 9 issues that were sent back to CPT for consideration and action. One of the issues was clarification of the instrumentation needed for Sacroiliac Arthrodesis, which is now on the agenda for this meeting. There was agreement to develop a number of CPT Assistant articles. The RUC also suggested exclusionary instructions in ECMO, which were put in place. Lastly the CPT application form is undergoing revision in order to bring it in line with the RUC survey questions and thresholds.

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

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

- CMS published the NPRM before July 4th and the comment period closed a few weeks ago.
- Some specialty societies have scheduled meetings with CMS to discuss concerns and others are welcome to do the same.
- The Final Rule for 2015 is scheduled to be published around November 1st

VII. Contractor Medical Director Update (Informational)

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

- There are 8 A/B MAC contracts serving 12 jurisdictions:
    - Novitas, has jurisdictions JH and JL with 24.1% of claims
    - NGS has jurisdictions JK and J6 with 21.6% of claims
    - Noridian has jurisdictions JE and JF with 14.7% of claims
    - WPS has jurisdictions J5 and J8 with 10.5% of claims
    - Palmetto has jurisdiction J11 with 8.9% of claims
    - First Coast has jurisdiction J9 with 8.4% of claims
    - Cahaba has jurisdiction J10 with 7.2% of claims
    - CGS has jurisdiction J15 with 5.9% of claims
- Coordination of local policies among the 8 A/B MAC contractors, developed by CMDs in conjunction with specialty societies:
    - Paravertebral Facet Joint Injections
    - Lumbar Epidural Steroid Injections
    - EMG/Nerve Conduction Studies
    - Autonomic Testing
    - Testing for Drugs of Abuse
- Coordination of editing for local policies, in the past this has been seen as proprietary, however trying to break barrier and have more uniform policies with the following two edits:
    - EMG/Nerve Conduction Testing
    - Paravertebral Facet Injections
- Policy coordination for molecular diagnostics:

  - Single contractor (Palmetto) with separate contract for assessing molecular diagnostics http://www.palmettogba.com/palmetto/MolDX.nsf/ is assessing each molecular diagnostic test.
    - Determines whether it fits into a benefit category
      - Lists tests on their website as either covered or non-covered.
    - Develops LCDs for some
      - Other contractors are not required to adopt these policies, but they often do and some contracts require this.
    - Facilitates detailed and unique identification through registration of molecular diagnostic tests to facilitate claims processing and to track utilization.
    - Establishes clinical utility expectations.
    - Completes technical assessments of published test data to determine clinical utility and coverage.
    - Establishes reimbursement.
  - Eleven policies developed so far:
    - Bladder Tumor Markers
    - Circulating tumor cells
    - CYP2C19, CYP2D6, CYP2C9, VKORC1
    - Lynch Syndrome
    - Infectious Diseases molecular tests
    - K-ras testing
    - Molecular diagnostic testing
    - NRAS Genetic Testing
    - GeneSight®
    - Breast Cancer Index SM ®
    - Confirm MDX Epigenetic Assay SM
  - Some are still proprietary despite a recent Supreme Court ruling – there is still uncertainty about which tests can and cannot be patented. This means that it still make sense to make a local coverage determination for each separate assay.
- Chemotherapy Administration Codes
  - New Chemotherapy administration codes issued in 2006 for those drugs requiring additional practice expense.
    - Concern among contractors of widespread misuse:
      - Billed with anti-nausea drugs, steroids, vitamins, etc., there may be some new edits to deal with this.
      - Some concern was raised with the OIG report in 2009 discussing dollars spent with Chemotherapy administration codes.
- Part A: Inpatient/Outpatient Conundrum
  - October 2013: New 2 midnight rule.
    - Issued to clarify boundary between an inpatient stay (Part A) and an Outpatient Stay (Part B) in order to reduce the claims payment error rate.
    - Critical question: Has the 2 midnight rule reduced the claims payment error rate?
      - Could possibly be answered by May 2015
  - Negotiated settlements for appeals for denied inpatient claims before 10/2013. This will be 68% of the expected fee. You can find information about this on the CMS website.
- Medical Review Contractors Most Reviews:
  - A/B MAC - reduce payment error rates.

- Recovery Auditor - recover incorrect payments.
- ZPIC - fraud and abuse.
- CERT - calculate claims payment error rate.
- SMRC - special CMS directed studies.

- Medical Review Contractors Less Frequent:
  - QIO - quality.
  - OIG, GAO - program evaluation.
  - OIG, DOJ - civil, criminal investigations.

VIII. Washington Update (Informational)

Sharon McIlrath, Assistant Director Federal Affairs, AMA, provided the RUC with the following information regarding the AMA's advocacy efforts:

- SGR Efforts
  - A year of work on the committees and medicine was killed over offsets
  - Lame duck Congress presents next opportunity but the prospects are uncertain and will be influenced by the following:
    - Election Results
    - Speakers' Race
    - Short Window
    - Controversy Avoidance
  - Pressure must continue
    - Environment next year
    - New Players
    - Tighter Budgets
    - Election Year Politics
  - AMA Efforts will Continue
    - District Meetings Scheduled
    - More than 100 Hill visits this week
- SGR Repeal Law
  - Focus on 3-committee SGR Repeal Bill (HR 4015/52000)
    - AKA SGR Repeal and Medicare Provider Payment Modernization Act
    - Permanent SGR Repeal
      - 2014-2018 annual updates = 0.5%
      - 2019 – 2023 = freeze
      - 2024 and thereafter = 0.5%
      - Compares to 0.3% per year 2001-14
    - New Merit Based Incentive Payment System (MIPS)
      - Blended PQRS, MU VBM and New Clinical Practice Improvement Option
      - Penalty(-4% to -9%) or bonus based on comparison to national mean
    - Alternative Payment Model Incentives
      - 5% bonus 2018 – 2023
      - 1% update 2024 and thereafter
  - Full Repeal is More Fiscally Responsible
    - Cost of 17 temporary fixes = $169.5b
    - Repeal Bill with extenders = $138.4b
    - 10 year freeze = 131 billion today

        - Was $117 billion in January
        - $124 billion in April
- Newest P4P Tool: Value-Based Payment Modifier
    - Required in ACA/Applied to all Medicare physician FFS claims
    - Budget Neutral
        - Size of bonuses depends on $ from penalties
    - Uses 2-yr old Cost and Quality Data
    - First Adjustments in 2015
        - Based on 2013 Cost and Quality Data
    - Two Step Process
        - Successful PQRS Participants Avoid Automatic Penalty
        - Then enter "Tiering" Competition
        - High Cost/Low Quality Groups Get Maximum Penalty
        - Low Cost/High Quality Groups Get Maximum Bonus
    - Aggressive Phase-In: More Penalties=Bigger Bonuses
        - 2015: 1% Maximum Penalty for Groups of 100+ EPs
            - Based on 2013 performance
            - PQRS Participation Group Level Only
            - 136 Entered Voluntary Tiering
            - Winners and Losers Announced Soon in QRURs
        - 2016: 2% Maximum Penalty for groups of 10+ EPs
            - Based on 2014 Performance
            - PQRS Reporting by Group or 50% of EPs
            - Mandatory Tiering but no Tiering Penalties in First Year
        - 2017: 4% Maximum Penalty for All Groups and Solo Practices
            - Based on 2015 Performance
            - Mandatory Tiering/No Tiering Penalty in First Year
            - Extended to all PQRS Eligible Professionals
            - ACOs/Pioneers and CMMI Initiatives Included
    - **Does Not Apply to Unassigned Claims**
- What is Tiering?
    - 2017: Potential -4% adjustment even for Successful PQRS Participants; Potential upward adjustment up to +4.0x
    - Eligible for an additional +1.0x. If reporting clinical data for quality measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores
- 2017 Value Modifier Measures
    - Quality Measures
        - PQRS reported measures
        - 3 claims-based outcome measures
            - Acute prevention quality indicators (pneumonia, UTI, dehydration)
            - Chronic prevention quality indicators (COPD, CHF, diabetes)
            - All Cause Readmissions
            - Must have 20 cases or measure not counted
            - CMS proposes to increase readmissions minimum to 200
- 2017: VBM Cost Measures
    - Aggregate Cost Measures:
        - Total Cost Per Capita

        - Medicare Spending Per Beneficiary (hospitalization/3 days pre/30 post)
    - Condition Specific
        - Patients With:
            - COPD
            - Heart Failure
            - CAD
            - Diabetes
    - Adjustments
        - Risk Adjustment
        - Price Standardization
        - No Site of Service Adjustments
    - Expected Results (based on 2012 Data)
        - If no practice failed PQRS, CMS predicts:
        - 80% would have no adjustment
        - 6% would have an upward adjustment
        - 11% would have a downward adjustment
        - 90,000 physicians and 35,000 other EPs penalized in 2017
        - Many groups would be defaulted to "average" due to no data
            - 42% percent of groups over 25 didn't have enough data for 2012 report
            - Most prevalent in single specialty groups
        - Physicians treating frailest patients more likely to incur penalty
            - CMS contractor found that a third of groups with sickest patients fell into high cost category compared to 8% of all groups
- Interactions
    - PQRS has gotten harder
        - 9 not 3 measures to avoid PQRS and VBM penalties
        - But CMS cut some measures, making it hard for everyone to participate
        - Administrative claims option gone
        - Mismatch between Meaningful Use and PQRS Reporting Policies
        - 36% of Physicians tried to participate in 2012, 31% were successful
        - Limiting informal review time to 30 days
        - Will PQRS failure rate increase or decrease?
    - The rules change every year
        - Even CMS can't always tell you what they are
        - Readmission example
    - Participation Made More Difficult by Clunky Portal
- AMA to CMS
    - Keep PQRS Measures and policies in place for at least 3 years
    - Reject measures not tested in physician practices
    - Improve Risk Adjuster; Include Socioeconomic Factors
    - 30 Day Review of PQRS and other reports is inadequate
    - Tell Congress VBM should be repealed or at least modified
    - Ask for more time and resources
    - Don't increase the VBM penalty and don't make tiering mandatory
    - Need better ways to adjust the specialty mix
    - Our comments on the rule are on the AMA website
    - Doing a new letter on all of the penalties
- Getting the Word Out
    - CMS will send letters to those getting PQRS and VBM penalties

- Main communication vehicle is Quality and Resource Use Reports
- These provide quality and cost information at group level with drill-downs
- 2013 Reports are late but should be out soon
- Those subject to VBM in 2015 will get information on adjustments
- Have until 1-31-15 for limited corrections in data and adjustment
- Correction time drops to 30 days in 2016
- Need individuals authorized Access to CMS computer services account
- See: http://cms.hhs.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/IACS?index.html
- To avoid 2016 penalty, must register as group by 9-30-14 of 50% PQRS participation

IX. Relative Value Recommendations for CPT 2015

Transcatheter Placement of Carotid Stents (Tab 4)
Richard Wright, MD (ACC); Matthew Sideman, MD (SVS); John Ratliff, MD (AANS); Alexander Mason, MD (CNS); Henry Woo, MD (CNS); Jerry Niedwiecki, MD (SIR); Kurt Schoppe, MD (ACR); Gregory Nicola, MD (ASNR) and Clifford Kavinsky, MD (SCAI)

In February 2013, the CPT Editorial Panel approved the creation of four new bundled codes to describe transcatheter placement of intravascular stent. Following this, the specialty societies noted that the code changes did not address antegrade stent placement in the innominate and intrathoracic carotid artery. In February 2014, the Panel created CPT Code 37218 to describe the antegrade treatment of the innominate artery and the intrathoracic common carotid artery. Additionally, the Panel added the words "open or" to the 37215 and 37216 CPT code descriptions to make them consistent with all other endovascular bundled coding.

In April 2014, the RUC did not recommend surveying: 37216 because it is a non-covered Medicare service, 37217 because it was reviewed by the RUC in April 2013 and codes 37235-37257 because they are not considered part of the family of services. The RUC noted that code 37215 has been performed consistently since its creation in 2006 and most recently was performed 8,455 times in 2013. Therefore, the RUC recommended that the specialty societies survey CPT code 37215 and present recommendations for physician work and practice expense at the September 2014 RUC meeting. Furthermore, the specialty societies were asked to provide a recommendation for the non-covered Medicare service 37216 to maintain the current magnitude estimation between the two services.

Prior to reviewing the survey data for CPT code 37215, the RUC discussed whether the vignette used in the survey accurately described the typical patient for this service. Specifically, the RUC discussed if it is necessary to describe the patient as having a history of external beam radiation therapy. The specialty societies explained that this history is important in describing the patient because it denotes that he or she cannot undergo an open procedure (endarterectomy). The specialties explained that this procedure is heavily regulated and, in fact, has its patient population mandated by the Centers for Medicare & Medicaid Services (CMS) through a National Coverage Determination (NCD). Therefore, the information presented in the vignette does not change the nature of the procedure; it simply specifies that the patient would qualify for this procedure under the rigorous CMS guidelines.

37215 ***Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection***
The RUC reviewed the survey results from 65 cardiologists, vascular surgeons, neurosurgeons, radiologists and neuroradiologists and approved pre-service time package 4 (Facility procedure, difficult patient, procedure) due to the complex nature of the unique patient population that is required for this procedure. The RUC noted that patients undergoing 37215 are inherently more difficult than patients receiving the other percutaneous procedures in this family (notably code 37218) because while both patients are still a risk of stroke, the procedure in the distal common carotid arteries adds the risk of cardiac arrhythmia and blood pressure derangement. Furthermore, the RUC also approved several modifications to the pre-service time package to account for the unique aspects of this procedure. An additional 35 minutes of pre-service evaluation was added to the standard as there are multiple pre-operative tests and images that must be reviewed for pre-operative planning. There was also 5 additional minutes added to pre-service positioning standard to account for placing the patient in fluoroscopic positioning. The RUC approved the following physician time components: pre-service time of 63 minutes, intra-service time of 90 minutes and immediate post-service time of 30 minutes.

Finally, the RUC noted that the survey respondents indicated a full-day discharge (99238), 2 level three office visits (99213) and 1 level three hospital visit (99233). The specialties noted that while the hospital visit is a higher level than the recently reviewed intrathoracic percutaneous code (37218), the disparity is appropriate because a patient undergoing 37215 has significant atherosclerotic vascular disease with multiple comorbidities and a high stroke risk.

The RUC reviewed the survey respondents estimated physician work and agreed that given the 7 percent drop in total time from the current time to the survey time (347 minutes and 322 minutes, respectively), the 25th percentile work RVU of 19.00 overestimates the physician work involved in the service. To determine the appropriate physician work value required to perform this service, the RUC reviewed CPT code 43770 *Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components)* (work RVU= 18.00) and noted that both services have identical intra-service time, 90 minutes, and comparable post-operative work. Therefore, the RUC recommends directly crosswalking the work RVU of 37215 to CPT code 43770. To justify a work RVU of 18.00, the RUC also compared the surveyed code to CPT code 27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment* (work RVU= 17.48) and agreed that while both services have identical intra-service time, 90 minutes, 37215 is a more intense procedure and is appropriately valued higher than the reference code. **The RUC recommends a work RVU of 18.00 for CPT code 37215.**

37216 ***Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection***
To maintain consistency within the family, the RUC also addressed CPT code 37216. This service is non-covered by Medicare and thus cannot be surveyed because of extremely low utilization. To value this procedure, the RUC noted that CPT code 37216 is identical to the work of 37215 but without the distal embolic protection device. All the pre- and post-service work (including the post-operative care) is identical. Therefore, given the inability

to collect survey data, the RUC recommends a direct crosswalk of both physician work and time from 37215 to CPT code 37216. **The RUC recommends a work RVU of 18.00 for CPT code 37216.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct PE inputs and approved the existing inputs, with the addition of 6 minutes (12 minutes total) to account for the clinical staff work involved in a full day discharge (99238). The RUC accepted the direct PE inputs as approved 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.

Database Flag
Due to the lack of a survey to derive the work value recommendation for CPT code 37216, the record will be flagged in the RUC database as not to be used to validate for physician work.

Appendix G
The RUC noted that the survey data indicated that only 52% of the services include moderate sedation in the hospital setting. Since moderate sedation is no longer inherent to CPT code 37215 it will be removed from the CPT Appendix G list.

Transient Elastography of Liver (Tab 5)
Dawn Francis, MD (AGA); Shivan Mehta, MD (AGA); Seth Goss (ASGE); Bruce Cameron, MD (ACG)

At the February 2014 CPT Editorial Panel meeting, the Panel created one new CPT Category I code to describe transient elastography of the liver. At the April 2014 RUC meeting, the RUC agreed that its recommendation for physician work and time would be interim due to the specialty's use of an incorrect survey instrument (000 Day Global Period, instead of XXX Global Period) and the survey not meeting the minimum threshold for respondents. Therefore, the specialty re-surveyed this service with the appropriate survey instrument and presented new survey results and recommendations for the September 2014 RUC meeting.

91200 ***Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report***
The RUC reviewed the survey results from 31 gastroenterologists and agreed that the 25th percentile intra-service time of 10 minutes accurately represents the typical length of intra-service physician work. The RUC recommends the following physician time components: pre-service time of 3 minutes, intra-service time of 10 minutes and post-service time of 5 minutes. The specialty elaborated that the actual measurements are typically performed separately by clinical staff and that an Evaluation and Management (E/M) service is not typically performed by the same physician that is interpreting the fibroscan measurements. Furthermore, they explained that the interpreting physician must evaluate the patient's history to make a cogent recommendation subsequent to reviewing the report. **The RUC deliberated this information and recommends referral to the CPT Editorial Panel for the inclusion of a parenthetical that prohibits the reporting of a same-day E/M visit with CPT code 91200.**

The RUC reviewed the survey respondents' estimated physician work values and agreed that they were overestimated, with a 25th percentile work RVU of 0.72. To determine an appropriate work value, the RUC compared the surveyed code to CPT code 78013 *Thyroid imaging (including vascular flow, when performed);* (work RVU= 0.37, 5 minutes of pre-time, 10 minutes of intra-time, 5 minutes of post-time) and noted that since both services have a similar intensity, identical intra-service times and comparable total times, they should be valued similarly. Therefore, the RUC recommends a direct work RVU crosswalk from code 78013 to surveyed code 91200.

To further justify a work RVU of 0.37 for 91200, the RUC reviewed CPT code 95981 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming* (work RVU= 0.30, intra-service time of 10 minutes and total time of 17 minutes), as well as CPT code 93016 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; supervision only, without interpretation and report* (work RVU= 0.45, intra-service time of 15 minutes and total time of 20 minutes), and agreed that the services represent analogous physician work and appropriately bracket the RUC recommended work RVU for the surveyed code with respect to physician time and intensity. **The RUC recommends a work RVU of 0.37 for CPT code 91200.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with minor modifications as approved by the Practice Expense Subcommittee. The RUC noted that the clinical labor time for staff type *diagnostic medical sonographer* (L050B), is disparate from the physician time for 91200.

Refer to CPT
The RUC recommends the CPT Editorial Panel include a parenthetical that prohibits the reporting of a same-day E/M visit with CPT code 91200. The RUC recommendation is contingent on the inclusion of this CPT parenthetical.

Database Flag
Due to the use of the survey 25th percentile for intra-service time and the use of a crosswalk to derive the work value recommendation for CPT code 91200, the record will be flagged in the RUC database as not to be used to validate for physician work.

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.

X. Relative Value Recommendations for CPT 2016:

<u>Sacroiliac Joint Fusion (Tab 6)</u>
John Ratliff, MD (AANS); Karin Swartz, MD (NASS); John Heiner, MD (AAOS); William Creevy, MD (AAOS)

In February 2014, the CPT Editorial Panel converted one Category III code to a Category I code to report minimally invasive sacroiliac joint fusion, which includes image guidance. Additionally, the CPT Editorial Panel revised CPT code 27280 to include the word "open."

27279 ***Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device***

In April 2014, the specialty societies indicated and agreed that the survey respondents overestimated the work required to perform CPT code 27279. The specialty societies noted that the survey process was interfered with by an outside party. Therefore, the specialty societies recommended and the RUC agreed that directly crosswalking 27279 to the work RVU of CPT code 62287 *Decompression procedure, percutaneous, of nucleus pulpous of intervertebral disc, any method utilizing needle based technique to remove disc material under fluoroscopic imaging or other form of indirect visualization, with the use of an endoscope, with discography and/or epidural injection(s) at the treated level(s), when performed, single or multiple levels, lumbar* (work RVU=9.03, 70 minutes pre-time, 60 minutes intra-time, 30 minutes post-time) is appropriate. The RUC recommends 55 minutes pre-service, 60 minutes intra-service and 30 minutes immediate post-service time for 27279. The RUC noted that both 27279 and 62287 require the same physician work and time to perform and therefore should be valued the same. For additional support, the RUC referenced MPC codes 49507 *Repair initial inguinal hernia, age 5 years or older; incarcerated or strangulated* (work RVU= 9.09) and 54530 *Orchiectomy, radical, for tumor; inguinal approach* (work RVU = 8.46), which require similar physician work and time and support the recommended work RVU of 9.03 for CPT code 27279. **In April 2014, the RUC recommended a work RVU of 9.03 for CPT code 27279. (Recommendation was submitted to CMS in May 2014).**

27280 ***Arthrodesis, open, sacroiliac joint including obtaining bone graft***

In April 2014, the specialty societies presented a letter to the RUC requesting that this code be referred back to the CPT Editorial Penal so that language can be added to the code clarifying that instrumentation is included in this procedure. The RUC agreed that this request is reasonable and referred this issue back to the CPT Editorial Panel to revise the descriptor to "includes instrumentation when performed". In the interim, the RUC recommended maintaining the current value of work RVU= 14.64 for this code. Specifically, the specialties reported to the RUC that the survey for CPT code 27280 led some respondents to believe that instrumentation could be reported separately even though it cannot and caused significant confusion. The specialty societies believed that a new survey using a revised descriptor would yield more accurate results. In April 2014, the RUC referred CPT Code 27280 to the CPT Editorial Panel. The RUC recommended that the current work RVU of 14.64 be maintained and that this service be resurveyed after revisions from the CPT Editorial Panel. (Recommendation was submitted to CMS in May 2014).

At the September 2014 RUC meeting, the specialties presented the results of their new survey for code 27280. The updated survey clarified that instrumentation cannot be separately reported. The specialty reported that technology has changed the manner in

which this procedure is performed. Specifically, arthrodesis of the SI joint with fixation is performed through a retroperitoneal approach with different and newer fixation devices that are more complex than what was available previously. The RUC approved compelling evidence for this procedure. The RUC reviewed the survey results from 97 physicians for CPT code 27280 and determined that the recommended work RVU of 20.00 which represents the survey 25th percentile, appropriately accounts for the work required to perform this service. The RUC noted that the current physician time is Harvard time and therefore recommends the surveyed time: 40 minutes pre-service evaluation, 18 minutes positioning, 15 minutes scrub/dress/wait, 120 minutes intra-service time and 30 minutes immediate post-service time. In response to an inquiry from CMS, the RUC clarified that this procedure only requires one surgeon and it would be unlikely that an approach surgeon would be necessary. The RUC compared 27280 to key reference service 22612 *Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed)* (work RVU = 23.53 and 150 minutes of intra-service time) and determined that 27280 requires 30 minutes less intra-service time and less physician work to complete. Therefore, 27280 is appropriately valued lower than key reference service 22612. For additional support the RUC referenced MPC codes 37215 *Transcatheter placement of intravascular stent(s), cervical carotid artery, percutaneous; with distal embolic protection* (work RVU = 19.68 and 103 minutes intra-service time) and 55866 *Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed* (work RVU = 32.06 and 210 minutes of intra-service time). Additionally, the RUC compared 27280 to 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);* (work RVU 17.31 and 120 minutes intra-service time). **The RUC recommends a work RVU of 20.00 for CPT code 27280.**

New Technology
The RUC recommends CPT codes 27279 and 27280 be placed on the New Technology list and be re-reviewed by the RUC to ensure correct valuation and utilization assumptions.

Practice Expense
The RUC recommends the standard 090-day global direct practice expense inputs as approved by the Practice Expense Subcommittee.

<u>Continuous Glucose Monitoring (Tab 7)</u>
Burt Lesnick, MD (ACCP); Alan Plummer (ATS)

In May 2014, the CPT Editorial Panel created two Category I codes to report continuous glucose monitoring via patient managed "real time" monitoring device and revised two Category I codes to report continuous glucose monitoring via provider managed "retrospective" monitoring device.

At the September 2014 RUC meeting, the specialty requested withdrawal of CPT codes 9525X1 and 9525X2 in order to take these codes back to CPT to restructure and better define the timeframe described. The specialty society has communicated with the CPT Editorial Panel requesting to rescind codes 9525X1 and 952X2 at the October 2014 CPT meeting to allow the specialties to submit a new coding change proposal. **The RUC recommends referral to the CPT Editorial Panel.**

Instrument –Based Ocular Screening -PE Only (Tab 8)
Steven Krug, MD (AAP); Stephen A. Kamenetzky, MD

In May 2014, the CPT Editorial Panel created a new code to describe instrument-based ocular screening (eg, photoscreening, automated refraction), bilateral; with on-site analysis and also revised the existing code for instrument-based ocular screening (eg, photoscreening, automated refraction), bilateral; with remote analysis and report to reflect the use of ocular screening instruments that perform both the screening and the analysis with report as well as the use of instruments that perform only the screening but require the analysis and report be done at a separate remote site after electronic transfer.

The specialty explained and the Practice Expense (PE) Subcommittee agreed that one minute above the standard is needed to prepare and position the patient to accommodate the typical patient, whom is a 3 year-old, pre-verbal child. Additionally, CPT code 99174 was developed with photography of the child from about one meter with a large camera, but has evolved to require more careful alignment of the instrument with the child's eyes to detect actual refractive error. This takes 1 minute longer for the RN/LPN/MTA (L037D) to perform then it did when this code was last reviewed in April 2008.

The PE Subcommittee determined that since this service is typically provided in conjunction with an evaluation and management (E/M) service, a phone call in the post-service period for 99174 is duplicative of the phones calls in the E/M and was removed from the direct PE inputs. The specialty had included a new supply item labeled, *fee, image analysis,* however the PE Subcommittee determined that this was not a disposable supply and similar fees are not paid for in other codes within the physicians payment schedule and therefore should not be included as a direct PE input.

The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

Office or Other Outpatient Observation – PE Only (Tab 9)
Mary M. Newman, MD, FACP (ACP); William Fox, MD (ACP)

Currently observation services are often only provided in the higher cost facility settings and are not paid for when they are provided in the outpatient setting. The CPT Editorial Panel created two new codes, 9935XX1 and 9935XX2, to describe hourly outpatient observation care clinical staff services during an evaluation and management (E/M) service in the office or outpatient setting.

There was extensive discussion regarding the correct coding of these services and determining if there is any overlap with the E/M service they are billed with. A representative of the CPT Editorial Panel clarified that 45 minutes of clinical staff time must elapse before this code can be used. The 45 minutes includes the time of the E/M, however if the E/M service is less than 45 minutes, 45 minutes still has to pass before this service can be billed. The threshold of 45 minutes is derived from the typical E/M service that would be billed as a parent code to this add-on code, 99214, which has 44 minutes of service period clinical staff time. The PE Subcommittee eliminated all clinical staff time other than the intra-service portion of the service period because the time is accounted for in the corresponding E/M service. In addition, supply items: *cookie (each)* (SK017); *cup,*

drinking (SK018); *ice (per cup)* (SK041); *drinking straw* (SK020); *juice, apple* (SK042), were removed as they are not included in similar services.

The Centers for Medicare & Medicaid Services raised concerns about editorial changes to the descriptors of CPT codes 99354 and 99355, adding the term, evaluation and management or psychotherapy, that were made in conjunction with the new prolonged services codes under review. The CPT Representative confirmed that these changes were made during the verbal discussion of the descriptors at the May CPT Editorial Panel Meeting and it was determined that they were editorial and did not require a survey for work. The Panel will review the change at the October CPT Editorial Panel Meeting and determine what the rationale was for the change in descriptors and if it is truly editorial or in fact changes the work and practice expense of the services by narrowing it to E/M or psychotherapy.

The RUC reviewed and approved the direct practice expense inputs with modifications as recommended by the Practice Expense Subcommittee.

XI. CMS Request/Relativity Assessment Identified Codes

Bone Biopsy Excisional (Tab 10)
William Creevy, MD (AAOS); Timothy H. Tillo, DPM (APMA)

In January 2014, the RUC reviewed 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with >1.5 office visits and 2012 Medicare utilization data over 1,000. The Relativity Assessment Workgroup agreed that CPT code 20245 should be surveyed at the September 2014 RUC meeting. The specialty society added CPT code 20240 as part of the family to be reviewed.

After surveying CPT codes 20240 and 20245, the specialties societies noticed several issues with the 010-day global period assignment for these codes. The varying nature of patients undergoing bone biopsies vary widely among the Medicare population. Patients range from having osteomyelitis or neoplasia, to others receiving the procedure to rule something else out who may otherwise have only minor pathology. Therefore, the amount of physician work, especially in the post-operative period, varies greatly depending on the patient population. As a result, there are large variations in the site-of-service and providers for each of these codes. The RUC agreed that both these services will need to be 000-day global periods in order to get meaningful survey responses. **The RUC requests that CMS change the global period from a 010-day global to a 000-day global for both CPT code 20240 and 20245 and the specialty societies will then survey for January 2015.**

Laryngoplasty (Tab 11)
Wayne Koch, MD and John Lanza, MD (AAO-HNS)

In January 2014, the RUC reviewed 090-day global services (based on 2012 Medicare utilization data) and identified code 31588 as a service reported at least 1,000 times per year that included more than 6 office visits. The specialty society added codes 31580, 31582, 31584 and 31587 as part of the family. The RUC recommended for all five codes to be surveyed for the September 2014 RUC meeting.

The specialty society noted that while reviewing this family of services, prior to survey, they noted that there were two reasons that this family of services should be referred to the CPT Editorial Panel. First, for some of the codes, the technology has changed; requiring modification to create new endoscopic codes that will more accurately represent the work being done. Second, due to low utilization for most of these codes, it may be appropriate to revise/delete any obsolete codes prior to conducting a RUC survey. **Given this information, the RUC agreed that this family of services should be referred to the CPT Editorial Panel for revisions.**

Laparoscopy Lymphadenectomy (Tab 12)
George Hill, MD (ACOG); and Barbara Goff, MD (ACOG)

In January 2014, the RUC reviewed all 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with greater than 1.5 office visits and 2012 Medicare utilization data over 1,000. The RUC requested these services be surveyed for physician work and for the work and practice expense to be reviewed at the September 2014 RUC meeting. At the September meeting, the RUC noted that even though the Medicare claims data indicate the potential for a hospital visit for these services, the typical patient for each of these service is younger than Medicare age (approximately 60 years old), following a clinical review and a review of the survey data, the RUC does not recommend the inclusion of a hospital visit for any of these services.

38570 ***Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple***
The RUC reviewed the survey results and agreed on the following physician time components: pre-service time of 53 minutes (the standard pre-time package 4, with 10 minutes removed from scrub, dress and wait to match the survey results of 38571), intra-service time of 60 minutes and immediate post-service time of 30 minutes (the standard post-service package 9B, with 3 minutes removed to match the survey results for this service). The RUC agreed with the specialty that a "difficult patient" pre-service package should be utilized, as the patient typically has metastatic prostate cancer with comorbidities (i.e. cardiovascular disease, BPH urinary retention, etc.). The RUC agreed that a full discharge day (99238) is appropriate for this inpatient procedure. The RUC also agreed that the following office visits during the 010-day global period were justified: one 99212 office visit which includes the removal of sutures, examination of wounds and checking for evidence of DVT or lymphocele, and one 99213 office visit which includes examination of wounds and primarily discussing pathology and what direction the patient will go for treatment (ie radiation treatment, hormonal therapy, etc.).

The RUC discussed the low number of survey responses and agreed that the low number was permissible, as the service had low Medicare utilization (2013 Medicare volume of 1,488) and urology only performed 38% of that volume in 2013.

The RUC reviewed the survey 25th percent work RVU of 12.00 and agreed with the specialty that the survey results were overvalued. The specialty societies indicated and the RUC agreed that the current work RVU of 9.34 appropriately accounts for the work required to perform this service. The RUC compared the surveyed code to CPT code 31239 *Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy* (work RVU= 9.04, intra-service time of 60 minutes, total time of 168 minutes) and noted that with identical intra-service time and higher total time, the current work value of 9.34 is an appropriate value relative to the comparator code. To further justify a work RVU of 9.34 for 38570,

the RUC reviewed MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU= 9.77, intra-service time of 60 minutes, total time of 207 minutes) and noted that both services have identical intra-service time, whereas the survey code has slightly more total time, which confirms that maintaining the current value for 38570 would be appropriate. **The RUC recommends a work RVU of 9.34 for CPT code 38570.**

38571 ***Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy***
The RUC reviewed the survey results from 32 urologists and agreed on the following physician time components: pre-service time of 53 minutes (the standard pre-time package 4, with 10 minutes removed from scrub, dress and wait to match the survey results), intra-service time of 90 minutes and immediate post-service time of 30 minutes (the standard post-service package 9B, with 3 minutes removed to match the survey results for this service). The RUC agreed with the specialty that the pre-time package should be for a "difficult patient", as the patient typically has metastatic prostate cancer with comorbidities (i.e. cardiovascular disease, BPH urinary retention, etc.). The RUC agreed that a full discharge day (99238) is appropriate for this inpatient procedure. The RUC also agreed that the following office visits during the 010-day global period were justified: one 99212 office visit which includes the removal of sutures, examination of wounds and checking for evidence of DVT or lymphocele, and one 99213 office visit which includes the examination of wounds and primarily discussing pathology and what direction the patient will go for treatment (ie radiation treatment, hormonal therapy, etc.).

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work RVU of 12.00 is appropriate. The RUC compared the survey code to the MPC code 53445 *Insertion of inflatable urethral/bladder neck sphincter, including placement of pump, reservoir, and cuff* (work RVU= 13.00, intra-service time of 90 minutes and total time of 314 minutes) and noted that both services have identical intra-service time, whereas the surveyed code has less total time, justifying a somewhat lower work value for the surveyed code. To further justify a work RVU of 12.00, the RUC reviewed CPT code 36818 *Arteriovenous anastomosis, open; by upper arm cephalic vein transposition* (work RVU= 11.89, intra-service time of 90 minutes, total time of 238 minutes) and noted that both codes have identical intra-service time, whereas the survey code has somewhat more total time (250 minutes vs. 238 minutes), which further justifies a work value of 12.00 for the survey code. **The RUC recommends a work RVU of 12.00 for CPT code 38571.**

38572 ***Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple***
The RUC reviewed the survey results from 97 gynecologists and gynecologic oncologists and agreed with the specialty on the following physician time components: 70 minutes of pre-service time (the standard pre-time package 4, with 12 minutes added to positioning and 5 minutes removed from scrub, dress and wait time), 120 minutes of intra-service time and 30 minutes of immediate post-service time (standard post-service package 9A). The RUC agreed with the specialty that 12 additional minutes above standard pre-service positioning time is warranted, as special attention is required to pad arms, legs, and pressure points when the patient is secured to the table to prevent patient movement when the patient is placed in the reverse Trendelenburg position or when the patient is turned from side to side. Additional time is also required for equipment positioning relative to the patient and to other equipment to insure access to the operative site, including the scope and video equipment, intra-operative imaging equipment, surgical instruments and anesthesia lines. Five minutes were removed from the standard scrub, dress and wait time

to match the survey results. The RUC agreed that a full discharge day (99238) is appropriate for this inpatient procedure. The RUC also agreed that the following office visits during the 010-day global period were justified: one 99214 office visit, which includes the inspection of the wound, abdomen, lymphatic system, neurologic and musculoskeletal systems and pelvic exam with a focus on swelling or irritation, as well as review of post-op lab results and instructing patient on analgesic use, bowel/bladder functions, and home medications; and one 99213 office visit, which includes discussion of pathology report and subsequent treatment options, as well as removal of sutures and examination of the wound.

The RUC reviewed the survey 25th percent work RVU of 20.00 and agreed with the specialty that the survey results were overestimated. To determine an appropriate work value, the RUC compared the surveyed code to MPC code 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU= 15.60, intra-service time of 120 minutes and total time of 313 minutes) and noted that since both services have identical intra-service time, similar total times (313 minutes vs. 321 minutes) and represent analogous physician work, they should be valued similarly. Therefore, the RUC recommends a direct work RVU crosswalk from code 60500 to survey code 38572.

To further justify a work RVU of 15.60 for CPT code 38572, the RUC reviewed CPT code *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU= 14.56, intra-service time of 120 minutes and total time of 279 minutes) and noted that both codes have identical intra-service times, whereas the surveyed code has more total time, which justifies a higher work value for 38572. **The RUC recommends a work RVU of 15.60 for CPT code 38572.**

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.

Practice Expense
The RUC reviewed and approved the direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

In January 2014, the RUC reviewed all 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with greater than 1.5 office visits and 2012 Medicare utilization data over 1,000. The RUC requested these services be surveyed for physician work and for the work and practice expense to be reviewed at the September 2014 RUC meeting. At the September meeting, the RUC noted that even though the Medicare claims data indicate the potential for a hospital visit for these services, the typical patient for each of these service is younger than Medicare age (approximately 60 years old), following a clinical review and a review of the survey data, the RUC does not recommend the inclusion of a hospital visit for any of these services.

38570 ***Laparoscopy, surgical; with retroperitoneal lymph node sampling (biopsy), single or multiple***
The RUC reviewed the survey results and agreed on the following physician time components: pre-service time of 53 minutes (the standard pre-time package 4, with 10

minutes removed from scrub, dress and wait to match the survey results of 38571), intra-service time of 60 minutes and immediate post-service time of 30 minutes (the standard post-service package 9B, with 3 minutes removed to match the survey results for this service). The RUC agreed with the specialty that a "difficult patient" pre-service package should be utilized, as the patient typically has metastatic prostate cancer with comorbidities (i.e. cardiovascular disease, BPH urinary retention, etc.). The RUC agreed that a full discharge day (99238) is appropriate for this inpatient procedure. The RUC also agreed that the following office visits during the 010-day global period were justified: one 99212 office visit which includes the removal of sutures, examination of wounds and checking for evidence of DVT or lymphocele, and one 99213 office visit which includes examination of wounds and primarily discussing pathology and what direction the patient will go for treatment (ie radiation treatment, hormonal therapy, etc.).

The RUC discussed the low number of survey responses and agreed that the low number was permissible, as the service had low Medicare utilization (2013 Medicare volume of 1,488) and urology only performed 38% of that volume in 2013.

The RUC reviewed the survey 25th percent work RVU of 12.00 and agreed with the specialty that the survey results were overvalued. The specialty societies indicated and the RUC agreed that the current work RVU of 9.34 appropriately accounts for the work required to perform this service. The RUC compared the surveyed code to CPT code 31239 *Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy* (work RVU= 9.04, intra-service time of 60 minutes, total time of 168 minutes) and noted that with identical intra-service time and higher total time, the current work value of 9.34 is an appropriate value relative to the comparator code. To further justify a work RVU of 9.34 for 38570, the RUC reviewed MPC code 50590 *Lithotripsy, extracorporeal shock wave* (work RVU= 9.77, intra-service time of 60 minutes, total time of 207 minutes) and noted that both services have identical intra-service time, whereas the survey code has slightly more total time, which confirms that maintaining the current value for 38570 would be appropriate. **The RUC recommends a work RVU of 9.34 for CPT code 38570.**

38571 ***Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy***
The RUC reviewed the survey results from 32 urologists and agreed on the following physician time components: pre-service time of 53 minutes (the standard pre-time package 4, with 10 minutes removed from scrub, dress and wait to match the survey results), intra-service time of 90 minutes and immediate post-service time of 30 minutes (the standard post-service package 9B, with 3 minutes removed to match the survey results for this service). The RUC agreed with the specialty that the pre-time package should be for a "difficult patient", as the patient typically has metastatic prostate cancer with comorbidities (i.e. cardiovascular disease, BPH urinary retention, etc.). The RUC agreed that a full discharge day (99238) is appropriate for this inpatient procedure. The RUC also agreed that the following office visits during the 010-day global period were justified: one 99212 office visit which includes the removal of sutures, examination of wounds and checking for evidence of DVT or lymphocele, and one 99213 office visit which includes the examination of wounds and primarily discussing pathology and what direction the patient will go for treatment (ie radiation treatment, hormonal therapy, etc.).

The RUC reviewed the survey respondents' estimated physician work values and agreed that the survey 25th percentile work RVU of 12.00 is appropriate. The RUC compared the survey code to the MPC code 53445 *Insertion of inflatable urethral/bladder neck*

sphincter, including placement of pump, reservoir, and cuff (work RVU= 13.00, intra-service time of 90 minutes and total time of 314 minutes) and noted that both services have identical intra-service time, whereas the surveyed code has less total time, justifying a somewhat lower work value for the surveyed code. To further justify a work RVU of 12.00, the RUC reviewed CPT code 36818 *Arteriovenous anastomosis, open; by upper arm cephalic vein transposition* (work RVU= 11.89, intra-service time of 90 minutes, total time of 238 minutes) and noted that both codes have identical intra-service time, whereas the survey code has somewhat more total time (250 minutes vs. 238 minutes), which further justifies a work value of 12.00 for the survey code. **The RUC recommends a work RVU of 12.00 for CPT code 38571.**

38572 ***Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple***

The RUC reviewed the survey results from 97 gynecologists and gynecologic oncologists and agreed with the specialty on the following physician time components: 70 minutes of pre-service time (the standard pre-time package 4, with 12 minutes added to positioning and 5 minutes removed from scrub, dress and wait time), 120 minutes of intra-service time and 30 minutes of immediate post-service time (standard post-service package 9A). The RUC agreed with the specialty that 12 additional minutes above standard pre-service positioning time is warranted, as special attention is required to pad arms, legs, and pressure points when the patient is secured to the table to prevent patient movement when the patient is placed in the reverse Trendelenburg position or when the patient is turned from side to side. Additional time is also required for equipment positioning relative to the patient and to other equipment to insure access to the operative site, including the scope and video equipment, intra-operative imaging equipment, surgical instruments and anesthesia lines. Five minutes were removed from the standard scrub, dress and wait time to match the survey results. The RUC agreed that a full discharge day (99238) is appropriate for this inpatient procedure. The RUC also agreed that the following office visits during the 010-day global period were justified: one 99214 office visit, which includes the inspection of the wound, abdomen, lymphatic system, neurologic and musculoskeletal systems and pelvic exam with a focus on swelling or irritation, as well as review of post-op lab results and instructing patient on analgesic use, bowel/bladder functions, and home medications; and one 99213 office visit, which includes discussion of pathology report and subsequent treatment options, as well as removal of sutures and examination of the wound.

The RUC reviewed the survey 25th percent work RVU of 20.00 and agreed with the specialty that the survey results were overestimated. To determine an appropriate work value, the RUC compared the surveyed code to MPC code 60500 *Parathyroidectomy or exploration of parathyroid(s);* (work RVU= 15.60, intra-service time of 120 minutes and total time of 313 minutes) and noted that since both services have identical intra-service time, similar total times (313 minutes vs. 321 minutes) and represent analogous physician work, they should be valued similarly. Therefore, the RUC recommends a direct work RVU crosswalk from code 60500 to survey code 38572.

To further justify a work RVU of 15.60 for CPT code 38572, the RUC reviewed CPT code *Laser enucleation of the prostate with morcellation, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, internal urethrotomy and transurethral resection of prostate are included if performed)* (work RVU= 14.56, intra-service time of 120 minutes and total time of 279 minutes) and noted that both codes have identical intra-service times,

whereas the surveyed code has more total time, which justifies a higher work value for 38572. **The RUC recommends a work RVU of 15.60 for CPT code 38572.**

Hemorrhoid(s) Injection (Tab 13)
Guy Orangio, MD FACS (ASCRS(col)); Charles Mabry, MD FACS (ACS); Michael Sutherland, MD FACS (ACS)

In January 2014, the RUC reviewed 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with >1.5 office visits and 2012 Medicare utilization data over 1,000. CPT code 46500 was identified by the RAW 010-day global post-operative visit screen with more than one post-op visit identified in the database. The RUC requested this service be surveyed for work and review the practice expense for the September 2014 RUC meeting.

46500 ***Injection of sclerosing solution hemorrhoid(s)***
The RUC reviewed the survey results from 46 colon and rectal and general surgeons for CPT code 46500 and determined that the current work RVU of 1.69, below the survey 25th percentile work RVU of 2.03, appropriately accounts for the work required to perform this service. The RUC noted that the current physician time is Harvard time based on responses from a few general surgeons and therefore recommends the survey time: 8 minutes pre-service evaluation, 5 minutes positioning, 3 minutes scrub/dress/wait, 10 minutes intra-service time, 10 minutes immediate post-service time, and one office visit (99213) [total time = 59 minutes]. The RUC agreed with the specialties that it was appropriate to subtract 9 minutes of evaluation time from pre-time package 6A to account for a separately reported distinct E/M service that data indicate may be reported approximately 55% of the time for Medicare patients. The RUC noted that 9 minutes is the time allocated in pre-time package 6A for "history and exam" and that the rest of the pre-time components in package 6A are related to an office based procedure with local/topical anesthesia care requiring wait time for anesthesia to take effect. Additionally, the RUC noted that diagnostic anoscopy may not be reported separately. The RUC compared 46500 to key reference service 46221 *Hemorrhoidectomy, internal, by rubber band ligation(s)* (work RVU = 2.36 and 15 minutes intra-service time) and determined that 46500 requires 5 minutes less intra-service time and less physician work to complete. Therefore, 46500 is appropriately valued lower than key reference service 46221. For additional support the RUC referenced CPT codes 11620 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less* (work RVU = 1.64 and 10 minutes intra-service time), 11640 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.5 cm or less* (work RVU= 1.67 and 10 minutes intra-service time), 67915 *Repair of ectropion; thermocauterization* (work RVU= 2.03 and 10 minutes of intra-service time)**,** and 67922 *Repair of entropion; thermocauterization* (work RVU= 2.03 and 10 minutes of intra-service time). **The RUC recommends a work RVU of 1.69 for CPT code 46500.**

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty societies and approved by the Practice Expense Subcommittee.

Liver Allotransplantation (Tab 14)
Michael Abecassis, MD FACS (ASTS); Charles Mabry, MD FACS (ACS)

In January 2014, the RUC reviewed 090-day global services (based on 2012 Medicare utilization data) and identified 10 services reported at least 1,000 times per year that included more than 6 office visits. The RUC requested these services be surveyed for work and the practice expense reviewed for the September 2014 RUC meeting.

Prior to reviewing the work RVU for CPT code 47135, the RUC reviewed four compelling evidence arguments provided by the specialty societies:

1. *Change in donor graft allocation*. Liver allocation has changed significantly since the last RUC review in 1994, when the dominant determinant of access to organs was time on the waiting list, with very few exceptions. Now, with the introduction in 2002 of the Model for End-stage Liver Disease (MELD), the true "sickest patients" (based on the likelihood of death without a transplant within 3 months) are the most likely to receive an organ.
2. *Change in donor graft characteristics*. In response to the increasing and unrelenting organ shortage, transplant surgeons continue their efforts to increase the donor pool, including accepting organs from suboptimal sources, including increasingly older donors. The result is that using higher risk grafts results in worse outcomes, and this effect is magnified in the higher risk recipients.
3. *Change in patient (recipient).*The median age for liver transplant patients has increased significantly since the previous review in 1994 and the number performed annually in patients aged 65 years or older quadrupled in the last twenty years. In addition, consistent with the trend in the general population toward increasing prevalence of obesity, the proportion of recipients with a high body mass index (BMI) has increased. The effects of obesity and diabetes have resulted in a higher prevalence of peripheral vascular disease, coronary artery disease and cerebrovascular disease at the time of transplant requiring more intense and complex physician work
4. *Flawed methodology related to postoperative visits* - While the RUC survey did collect physician time for 47135 in 1994, the survey did not request the number and level of hospital and office visits. The current allocation of 23 level one hospital visits and 7 office visits was derived as an estimate from the survey post-operative time. Therefore, the current number and level of postoperative visits are not based on an actual assessment/survey of the services provided.

The RUC agreed that there is compelling evidence that the current work for 41735 may have changed.

47135 Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age

The RUC reviewed the survey data from 102 transplant surgeons and extensively discussed the physician time and postoperative visits. The RUC agreed that pre-package 4 (Facility: Difficult patient, Difficult procedure) with additional time was appropriate due to the complex physician pre-service work required for liver transplantation. The RUC agreed that 50 minutes additional evaluation time, for a total of 90 minutes, appropriately accounted for the surgeon's significant pre-operative work to thoroughly evaluate both the patient and the graft prior to surgery and to "match" the donor graft with the patient. An additional 17 minutes of positioning time was also approved, for a total of 20 minutes, to position the patient for midline and both left and right subcostal incisions and axilla and groin incisions for venous access for partial (systemic) bypass. Finally, the RUC approved 10 additional minutes of scrub, dress, wait time to the package, for a total of 30 minutes, to account for the frequent delays necessitated while

trying to optimize minimization of donor ischemic time with minimization of intra-operative delays while waiting for organ arrival and backbench preparation. The RUC noted that the additional minutes added to each category of pre-service work is consistent with other recently reviewed transplant codes.

The RUC also agreed that the survey median immediate post-service time of 75 minutes was appropriate due to the critical care monitoring of the patient by the surgeon following surgery. The specialties indicated that the patient is transported still under anesthesia directly from the operating room to the ICU, and without exception is intubated, bagged during transport, and placed on a ventilator on arrival to the ICU. Postoperative recovery care is performed in the ICU instead of a recovery room. The surgeon monitors hemodynamic and laboratory parameters and expectations of graft function are discussed with anesthesia and nursing staff. Hourly blood gas measurement and urine output are monitored. Ventilator adjustments are made to maintain ventilation and oxygenation. The surgeon is also monitoring for immediate graft function and providing consultation to the family during this time. The specialties indicated that the surgeon's work is contiguous and therefore the survey respondents did not indicate a separate critical care visit on the day of surgery.

The RUC recommends the following physician time components for CPT code 47135: pre-service time of 140 minutes, intra-service time of 420 minutes and immediate post-service time of 75 minutes.

The RUC also discussed the significant post-operative work required within the 090-day global period. The RUC noted that the survey median hospital length of stay is 13 days. This data is consistent with the median Medicare data for MS-DRG 005 length of stay, 14 days, and the University HealthSystem Consortium® (UHC) median length of stay of 21 days. The RUC also agreed that eight office visits are appropriate for the post-discharge care. The number and level of visits were deemed appropriate with one 99215, six 99214 and one 99213. These visits are justified by not only the high complexity level of decision making and comprehensive examination, but also the extensive amount of time it takes to perform these visits because the patient will likely have been seen and/or monitored by other transplant team providers (eg, pharmacists, home health care, therapy, dietician) who have entered notes in the medical record, require review and coordination of services. Significant counseling and discussion with the patient and family is typical as there are many questions to be addressed. These initial visits typically take at least an hour, with subsequent office visits taking 30-45 minutes due to the complexity of monitoring and managing complications. The RUC acknowledged that the post-service description of work supports the number and level office visits.

Following this lengthy discussion of physician time and post-operative work, the RUC reviewed the survey respondents' work RVU recommendation and agreed with the specialties that the survey median work RVU of 91.78 is appropriate. To justify a work RVU of 91.78, the RUC compared the survey code to the key reference service CPT code 47142 *Donor hepatectomy (including cold preservation), from living donor; total right lobectomy (segments V, VI, VII and VIII)* (work RVU= 79.44, 480 minutes of intra-service time) and noted that while the reference code has slightly more intra-service time, the survey code has significantly more total time, 1,648 minutes and 1,221 minutes, respectively, and is thus appropriately valued higher. The RUC also referenced three other transplant codes: 32854 *Lung transplant, double (bilateral sequential or en bloc); with cardiopulmonary bypass* (work RVU= 90.00, intra-service time= 400 minutes, total

time=1,600), 33935 *Heart-lung transplant with recipient cardiectomy-pneumonectomy* (work RVU= 91.78, intra-service time= 380 minutes, total time=1,713) and 43116 *Partial esophagectomy, cervical, with free intestinal graft, including microvascular anastomosis, obtaining the graft and intestinal reconstruction* (work RVU= 92.99, intra-service time= 561 minutes, total time=1,403). In choosing these additional reference codes, the RUC agreed that the similar intra-operative work intensity supported the intra-operative work intensity for 47135. In addition, the RUC noted that all three of the comparator codes involve complex and intense operative work and significant postoperative care that accurately bracket the recommended work value for code 47135. **The RUC recommends a work RVU of 91.78 for CPT code 47135.**

Practice Expense
The Practice Expense Subcommittee reviewed the direct PE inputs and noted that these recommendations represent the 090-day global standard with additional pre-service clinical staff time that is consistent with other transplant codes. The Subcommittee also noted that the increased post-service clinical labor time resulted from the change in number and level of physician office visits that the RUC approved. The RUC approved the direct PE inputs as recommended by the PE Subcommittee.

Dilation and Probing of Lacrimal and Nasolacrimal Duct (Tab 15)
Stephen A. Kamenetzky, MD (AAO); David B. Glasser, MD (AOA); Charlie Fitzpatrick. OD, (AOA)

In January 2014, the RUC reviewed 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with >1.5 office visits and 2012 Medicare utilization data over 1,000. The RUC requested these services be surveyed for work and review the practice expense for the September 2014 RUC meeting.

The RUC agreed that CPT codes 68811 and 68816 are also part of this code family and were left off in error. Therefore, the RUC recommendations for physician work and time are interim. The RUC requested that the specialty re-survey with the appropriate survey instrument for the January 2015 RUC meeting.

68801 ***Dilation of lacrimal punctum, with or without irrigation***
The RUC reviewed the survey results from 76 ophthalmologists and optometrists and agreed on the following physician time components: pre-service time of 4 minutes (with 17 minutes less evaluation time, 1 minute of additional positioning time and 3 minutes less scrub, dress and wait time relative to the standard 6A pre-time package), intra-service time of 5 minutes and immediate post-service time of 5 minutes (post-service package 7A minus 13 minutes). The pre-time was reduced relative to the standard package, as this service is typically done in the office setting in conjunction with a separate E/M visit. The pre-service time includes 2 minutes to allow for positioning of the conscious patient and 2 minutes for the administration of topical anesthesia. The RUC agreed with the specialty that one 99212 office visit during the 010-day global period is justified in order to examine the patient and see if there is patency of the lacrimal system.

The RUC reviewed the survey 25th percent work RVU of 1.04 and agreed with the specialty societies that the current value of 1.00 is appropriate for this service. The RUC compared the survey code to CPT code 64611 *Chemodenervation of parotid and*

submandibular salivary glands, bilateral (work RVU= 1.03, 5 minutes of intra-service time, 36 minutes of total time) and noted that since the codes have identical intra-service times, the same number and level of office visits, and similar total times, the similar work values are justified. Additionally, the RUC compared the survey code to CPT code 65778 *Placement of amniotic membrane on the ocular surface; without sutures* (work RVU= 1.19, 5 minutes of intra-service time and 31 minutes of total time) and noted that the survey code has identical intra-service times, the same number and level of office visits, and a similar total time, and is therefore, correctly valued similarly to 65778. **The RUC recommends an interim work RVU of 1.00 for CPT code 68801.**

68810 ***Probing of nasolacrimal duct, with or without irrigation;***
The RUC reviewed the survey results from 46 ophthalmologists and ocular plastic surgeons and agreed with the specialty on the following physician time components: pre-service time of 17 minutes, with 7 minutes less evaluation time and 1 minute of additional positioning time relative to the standard 6A pre-time package, intra-service time of 15 minutes and immediate post-service time of 5 minutes (post-service package 7A minus 13 minutes). The pre-time was reduced relative to the standard package, as this service is typically done in the office setting in conjunction with a separate E/M visit. The pre-service time is greater than for 68801 because the eye and nasolacrimal system takes longer to anesthetize and position the patient to be able to pass the probe comfortably. The pre-service time includes 2 minutes to allow for positioning of the conscious patient and 5 minutes for the administration of topical anesthesia. The RUC agreed with the specialty that one 99212 office visit during the 010-day global period is justified in order to examine the patient and see if there is patency of the lacrimal system.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 1.95 is appropriate. The RUC compared the survey code to MPC code 11641 *Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 0.6 to 1.0 cm* (work RVU= 2.17, pre-service time of 15 minutes, intra-service time of 20 minutes and post-service time of 5 minutes) and noted that the survey code has lower intra-service time and total time, and is therefore, appropriately valued somewhat lower than 11641. Additionally, the RUC compared the survey code to 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, pre-service time of 15 minutes, intra-service time of 15 minutes and post-service time of 5 minutes) and noted that both codes have identical intra-service time, whereas the survey code has a longer total time, justifying a somewhat higher RVU. **The RUC recommends an interim work RVU of 1.95 for CPT code 68810.**

68815 ***Probing of nasolacrimal duct, with or without irrigation; with insertion of tube or stent***
The RUC reviewed the survey results from 45 ophthalmologists and ocular plastic surgeons and agreed with the specialty on the following physician time components: pre-service time of 25 minutes (standard pre-time package 1B), intra-service time of 25 minutes and post-service time of 15 minutes (post-time package 8A minus 10 minutes). The RUC acknowledged that unlike the other survey codes in the family, this service is typically done in a facility, not with a separate E/M visit and under general anesthesia. The societies subtracted 10 minutes from the standard post-time package in order to

match the survey results. The RUC agreed with the specialty that a ½ day discharge visit (99238) is appropriate for this procedure that is typically performed in a facility. The RUC also concurred that two 99212 office visits during the 010-day global period are justified in order to reflect the increased complexity of managing the patient with the stent in place. The patient is typically a young child, which also contributes to the added complexity.

The RUC reviewed the survey respondents' estimated physician work values and agreed with the specialty societies that the survey 25th percentile work RVU of 3.06 is appropriate. The RUC compared the survey code to CPT code 58120 *Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)* (work RVU= 3.59, intra-service time of 25 minutes and total time of 129 minutes) and noted that since both services have identical intra-service time and the survey code has less total time (116 minutes vs. 129 minutes), a somewhat lower work RVU for the survey code is justified. Additionally, the RUC compared the survey code to MPC code 11623 *Excision, malignant lesion including margins, scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm* (work RVU= 3.11, intra-service time of 30 minutes and total time of 93 minutes) and noted that with less intra-service time, though more total time, the survey code is appropriately valued comparably to MPC code 11623. **The RUC recommends an interim work RVU of 3.06 for CPT code 68815.**

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.

Practice Expense
The RUC reviewed and approved the interim direct practice expense inputs with modifications as approved by the Practice Expense Subcommittee.

<u>Laminectomy (Tab 16)</u>
Alexander Mason, MD (CNS); John Ratliff, MD (AANS); Henry Woo, MD (CNS); Karin Swartz, MD (NASS); William Creevy, MD (AAOS); and John Heiner, MD (AAOS)

In 2011, CMS identified CPT code 63047 as potentially misvalued through the CMS High Expenditure Procedural Codes screen. The specialty societies added CPT code 63048 to be reviewed as part of this family of services. The RUC submitted recommendations for codes 63047 and 63048 for CY 2014. In the Final Rule for 2014, CMS requested that CPT codes 63045 and 63046 be reviewed in concert with 63047 and 63048 and valued these services as interim until 63045 and 63046 are reviewed.

No specialty societies indicated an interest to survey these services. The specialty societies who typically perform these services, and the RUC, commented that CMS should have requested that these services be reviewed when the Agency initially identified CPT code 63047. Nevertheless, the specialty societies indicated that these two sets of services are not in the same family. The specialty societies noted that 63045 and 63046 represent very different physician work; the spinal cord is present at these levels, and the techniques for bone removal as well as physician stress and risk of complications are very different as a result. In addition, 63045 and 63046 represent a small proportion

(<15%) of the aggregate volume of what CMS has now declared to be the "family" of codes.

The RUC agreed that it would have been less burdensome on the specialty societies if all of these services were identified and surveyed at the same time. However, the RUC noted that the Medicare utilization is slowly increasing for these Harvard-valued services and both codes should be surveyed. The RUC recommended that CPT codes 63045 and 63046 be surveyed for September 2014.

63045 ***Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; cervical***
The RUC reviewed the survey results from 75 physicians for CPT code 63045 and determined that the current work RVU of 17.95, slightly below the survey 25th percentile work RVU of 18.00, appropriately accounts for the work required to perform this service. The RUC noted that the current physician time is Harvard extrapolated time and therefore recommends the surveyed time: 40 minutes pre-service evaluation, 18 minutes positioning, 20 minutes scrub/dress/wait, 120 minutes intra-service time and 30 minutes immediate post-service time. The RUC compared 63045 to key reference service 63015 *Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical* (work RVU = 20.85 and 150 minutes intra-service time) and determined that 63045 requires 30 minutes less intra-service time and less physician work to complete. Therefore, 63045 is appropriately valued lower than key reference service 63015. For additional support the RUC referenced MPC codes 33249 *Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber* (work RVU 15.17 and 120 minutes intra-service time) and 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);* (work RVU 17.31 and 120 minutes intra-service time). **The RUC recommends a work RVU of 17.95 for CPT code 63045.**

63046 ***Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; thoracic***
The RUC reviewed the survey results from 75 physicians for CPT code 63046 and determined that the current work RVU of 17.25, slightly below the survey 25th percentile work RVU of 17.78, appropriately accounts for the work required to perform this service. The RUC noted that the current physician time is Harvard extrapolated time and therefore recommends the surveyed time: 40 minutes pre-service evaluation, 18 minutes positioning, 20 minutes scrub/dress/wait, 120 minutes intra-service time and 30 minutes immediate post-service time. The RUC compared 63046 to key reference service 63047 *Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar* (work RVU = 15.37 and 90 minutes intra-service time) and determined that 63046 requires 30 minutes more intra-service time and more physician work to complete. Therefore, 63046 is appropriately valued higher than key reference service 63047. For additional support the RUC referenced MPC codes 33249 *Insertion or replacement of permanent pacing cardioverter-defibrillator system with transvenous lead(s), single or dual chamber* (work RVU 15.17 and 120 minutes intra-service time) and 58150 *Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);* (work RVU 17.31 and

120 minutes intra-service time). **The RUC recommends a work RVU of 17.25 for CPT code 63046.**

Practice Expense
The RUC recommends the direct practice expense inputs as submitted by the specialty societies and approved by the Practice Expense Subcommittee.

X-Ray Exams (Tab 17)
Zeke Silva, MD; Kurt Schoppe, MD (ACR)

In April 2013, the RUC identified six of these services through the CMS/Other Source – Utilization over 250,000 screen. In October 2013, the RUC noted that these services were never RUC reviewed but are frequently reported. The RUC recommended that these services be surveyed for physician work and develop direct practice expense inputs for the January 2014 RUC meeting. At the January meeting the specialty societies provided specific crosswalks to existing RUC surveyed x-ray codes to support the existing values of these six services. However, the RUC indicated they requested that these services be surveyed for physician work and direct practice expense inputs for April 2014. Anticipating the volume of radiology codes that were scheduled to be reviewed at the April 2014 RUC meeting, the specialty requested that review of these services be postponed to the September 2014 RUC meeting. The 2015 NPRM included 3 additional codes in the knee anatomic region, which were also surveyed by the specialty societies.

71100 ***Radiologic examination, ribs, unilateral; 2 views***
The RUC reviewed the survey results from 54 radiologists and agreed with the specialty society that the following physician time components are appropriate for this service: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 71100 and determined that the survey 25th percentile and current work RVU of 0.22 is appropriate for this service. The RUC compared the surveyed code to key reference service 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU = 0.22 and total time = 6 minutes) and determined that both services require the same total physician time and should be valued identically. For additional support, the RUC referenced CPT code 72040 *Radiologic examination, spine, cervical; 2 or 3 views* (work RVU = 0.22 and total time = 6 minutes) and 72120 *Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views* (work RVU = 0.22 and total time = 6 minutes). **The RUC recommends a work RVU of 0.22 for CPT code 71100.**

72070 ***Radiologic examination, spine; thoracic, 2 views***
The RUC reviewed the survey results from 105 radiologists, neuroradiologists and orthopaedic surgeons and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 72070 and determined that the survey 25th percentile and current work RVU of 0.22 is appropriate for this service. The RUC had a robust discussion about the number of views for radiologic examination codes and clarified that it is not the number of views, but rather the region of the body that determines the intensity and complexity of a

service. Therefore the surveyed code examining the thoracic spine has the same number of views and surveyed physician time as various extremity codes included in this recommendation, such as, 73060 *Radiologic examination; humerus, minimum of 2 views*, 73560 *Radiologic examination, knee; 1 or 2 views,* and 73600 *Radiologic examination, ankle; 2 views,* yet, appropriately has a higher physician work value. The RUC compared the surveyed code to key reference service 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU = 0.22) and determined that both services require similar physician time, intensity and complexity to perform and should be valued similarly. **The RUC recommends a work RVU of 0.22 for CPT code 72070.**

73060 ***Radiologic examination; humerus, minimum of 2 views***
The RUC reviewed the survey results from 59 radiologists and orthopaedic surgeons and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 73060 and determined that the survey 25th percentile work RVU of 0.16 is appropriate for this service. The RUC compared the surveyed code to MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16 and total time = 5 minutes) and determined that both services require the same physician time components and should be valued identically. For additional support, the RUC referenced CPT code 73100 *Radiologic examination, wrist; 2 views* (work RVU = 0.16 and total time = 5 minutes) and 73620 *Radiologic examination, foot; 2 views* (work RVU = 0.16 and total time = 5 minutes). **The RUC recommends a work RVU of 0.16 for CPT code 73060.**

73560 ***Radiologic examination, knee; 1 or 2 views***
The RUC reviewed the survey results from 80 radiologists and orthopaedic surgeons and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 73560 and determined that the survey 25th percentile work RVU of 0.16 is appropriate for this service. The RUC compared the surveyed code to MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16 and total time = 5 minutes) and determined that both services require the same physician time components and should be valued identically. For additional support, the RUC referenced CPT code 72170 *Radiologic examination, pelvis; 1 or 2 views* (work RVU = 0.17 and total time = 7 minutes) and determined that the surveyed code had the same number of views, but required less physician time and was appropriately valued lower. The RUC also compared the surveyed code to 73620 *Radiologic examination, foot; 2 views* (work RVU = 0.16 and total time = 5 minutes). **The RUC recommends a work RVU of 0.16 for CPT code 73560.**

73562 ***Radiologic examination, knee; 3 views***
The RUC reviewed the survey results from 75 radiologists and orthopaedic surgeons and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 1 minute, intra-service time of 4 minutes and post-service time of 1 minute.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 73562 and determined that the current work RVU of 0.18, below the survey 25th percentile, is appropriate for this service. The RUC compared the surveyed code to key reference service 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU = 0.22 and total time = 6 minutes) which is also an MPC code and determined that both services require the same total physician time; however, lumbosacral spine is a more intense and complex region of the body to view and interpret relative to the knee and, therefore, the comparator code is appropriately valued somewhat higher. For additional support, the RUC referenced CPT code 73030 *Radiologic examination, shoulder; complete, minimum of 2 views* (work RVU = 0.18), with identical intra-service time, 4 minutes, and determined that the codes should be valued identically. **The RUC recommends a work RVU of 0.18 for CPT code 73562.**

73564 ***Radiologic examination, knee; complete, 4 or more views***
The RUC reviewed the survey results from 78 radiologists and orthopaedic surgeons and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 1 minute, intra-service time of 5 minutes and post-service time of 1 minute.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 73564 and determined that the survey 25th percentile and current work RVU of 0.22 is appropriate for this service. The RUC compared the surveyed code to MPC code 72100 *Radiologic examination, spine, lumbosacral; 2 or 3 views* (work RVU = 0.22 and intra-service time = 3 minutes) and determined that the survey code requires more intra-service physician time to account for the additional views; however, the comparison code has a more intense and complex region of the body to view and interpret, and, therefore the codes should be valued similarly. For additional support, the RUC referenced MPC code 72110 *Radiologic examination, spine, lumbosacral; minimum of 4 views* (work RVU = 0.31) and 70355 *Orthopantogram (eg, panoramic x-ray)* (work RVU = 0.22). **The RUC recommends a work RVU of 0.22 for CPT code 73564.**

73565 ***Radiologic examination, knee; both knees, standing, anteroposterior***
The RUC reviewed the survey results from 121 radiologists and orthopaedic surgeons and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 73565 and determined that the survey 25th percentile work RVU of 0.16 is appropriate for this service. The RUC compared the surveyed code to MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16 and total time = 5 minutes) and determined that both services require the same physician time components and should be valued identically. For additional support, the RUC referenced CPT code 73100 *Radiologic examination, wrist; 2 views* (work RVU = 0.16 and total time = 5 minutes) and 73620 *Radiologic examination, foot; 2 views* (work RVU = 0.16 and total time = 5 minutes). **The RUC recommends a work RVU of 0.16 for CPT code 73565.**

73590 ***Radiologic examination; tibia and fibula, 2 views***
The RUC reviewed the survey results from 59 radiologists and orthopaedic surgeons and agreed with the specialty societies that the following physician time components are

appropriate for this service: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 73590 and determined that the survey 25th percentile work RVU of 0.16 is appropriate for this service. The RUC compared the surveyed code to key reference service 73620 *Radiologic examination, foot; 2 views* (work RVU = 0.16 and total time = 5 minutes) and determined that both services require the same physician time components and should be valued identically. For additional support, the RUC referenced MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16 and total time = 5 minutes) and CPT code 73100 *Radiologic examination, wrist; 2 views* (work RVU = 0.16 and total time = 5 minutes). **The RUC recommends a work RVU of 0.16 for CPT code 73590.**

73600 ***Radiologic examination, ankle; 2 views***
The RUC reviewed the survey results from 179 radiologists, podiatrists and orthopaedic surgeons and agreed with the specialty societies that the following physician time components are appropriate for this service: pre-service time of 1 minute, intra-service time of 3 minutes and post-service time of 1 minute.

The RUC reviewed the survey respondents' estimated physician work values for CPT code 73600 and determined that the current work RVU of 0.16, below the survey 25th percentile, is appropriate for this service. The RUC compared the surveyed code to key reference service 73620 *Radiologic examination, foot; 2 views* (work RVU = 0.16 and total time = 5 minutes) and determined that both services require the same physician time components and should be valued identically. For additional support, the RUC referenced MPC code 73120 *Radiologic examination, hand; 2 views* (work RVU = 0.16 and total time = 5 minutes) and CPT code 73100 *Radiologic examination, wrist; 2 views* (work RVU = 0.16 and total time = 5 minutes). **The RUC recommends a work RVU of 0.16 for CPT code 73600.**

Practice Expense
The RUC reviewed and approved the direct practice expense inputs as submitted by the specialty society and recommended by the Practice Expense Subcommittee.

Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s) (Tab 18)
Jonathan Myles, MD, FCAP (CAP); Roger Klein, MD, JD (CAP)

The RUC reviewed the survey results for these services at the April 2014 RUC meeting. The RUC noted that CPT codes 88367 and 88368 did not meet the RUC established survey response criteria of 50 responses for codes with Medicare Claims between 100,000 – 1 million. The specialty societies re-opened their survey and brought back these codes with more than 50 responses for the RUC to review in September 2014.

88367 ***Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-assisted technology, per specimen; initial single probe stain procedure***

The RUC reviewed the survey results for CPT code 88367 and determined the previous interim recommendation based on the survey 25th percentile work RVU of 0.86 appropriately accounts for the work required to perform this service. The RUC recommends 25 minutes of intra-service time for this service. The specialty society noted

and the RUC agreed that "using computer-assisted technology" for 88367, as included in the descriptor, does not replace the need for physician interpretation. Computer-assisted technology refers to the computer selecting the images for the pathologist to review. The computer does not adequately distinguish between cancer and non-cancer cells. In addition, the American Society of Clinical Oncology (ASCO) guidelines indicate that a minimum of 40 neoplastic cells need to be examined for signal intensity. The RUC compared 88367 to 88368 *Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure* (RUC recommended work RVU= 0.88) and noted that CPT code 88368 is manual and requires slightly more physician work and time because the physician is moving the fluoroscopic microscope around to find the cells of interest that will be counted. In code 88367, the images that the physician evaluates are selected by the computer. CPT code 88367 still requires the physician to analyze and make decisions. The RUC also noted that 88367 requires less Lab Tech/Histotechnician time in the practice expense because the computer is selecting the images instead. The specialty societies explained that if the RUC recommended the new combined survey 25th percentile work RVU of 0.90 for both 88367 and 88368, this would cause a rank order anomaly. The specialty societies reiterated that slightly more physician work is required for 88368 and the recommendation reflects that. The RUC compared 88367 to reference service 88346 *Immunofluorescent study, each antibody; direct method* (work RVU= 0.86) and agreed that since these services require the same physician work to perform, a work RVU of 0.86 is appropriate. The RUC also compared 88367 to reference service 88121 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; using computer-assisted technology* (work RVU = 1.00) and agreed that these services are similar. For additional support the RUC referenced MPC codes 51705 *Change of cystostomy tube; simple* (work RVU = 0.90) and 88305 *Level IV - Surgical pathology, gross and microscopic examination* (work RVU = 0.75), CPT code 78306 *Bone and/or joint imaging; whole body* (work RVU = 0.86) and 86079 *Blood bank physician services; authorization for deviation from standard blood banking procedures (eg, use of outdated blood, transfusion of Rh incompatible units), with written report* (work RVU = 0.94). **The RUC recommends a work RVU of 0.86 for CPT code 88367.**

88368 ***Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), manual, per specimen; initial single probe stain procedure***

The RUC reviewed the survey results for CPT code 88368 and determined that the survey 25th percentile work RVU of 0.88 appropriately accounts for the work required to perform this service. The RUC recommends 30 minutes intra-service time for this service. The RUC compared 88367 to 88368 and noted that CPT code 88368 is manual and requires slightly more physician work and time because the physician is moving the fluoroscopic microscope around to find the cells of interest that will be counted. The specialty societies explained that if the RUC recommended the new combined survey 25th percentile work RVU of 0.90 for both 88367 and 88368, this would cause a rank order anomaly. The specialty societies reiterated that slightly more physician work is required for 88368 and the recommendation reflects that. The RUC compared 88368 to key reference service 88120 *Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes, each specimen; manual* (work RVU = 1.20) and determined that although 88368 requires the same physician time to perform, 30 minutes, it requires less work, as it accounts for the use of a single probe. For additional support the RUC referenced MPC code 51705 *Change of cystostomy tube;*

simple (work RVU = 0.90 and total time 32 minutes) and similar services 88346 *Immunofluorescent study, each antibody; direct method* (work RVU = 0.86), 86077 *Blood bank physician services; difficult cross match and/or evaluation of irregular antibody(s), interpretation and written report* (work RVU = 0.94), 88358 *Morphometric analysis; tumor (eg, DNA ploidy)* (work RVU = 0.95) and 88360 *Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, each antibody; manual* (work RVU = 1.10). **The RUC recommends a work RVU of 0.88 for CPT code 88368.**

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

Practice Expense
The RUC recommends the direct practice expense inputs as modified by the Practice Expense Subcommittee at the April 2014 meeting.

Immunofluorescent Study (Tab 19)
Jonathan L. Myles, MD, FCAP (CAP)

In April 2013, the RUC identified CPT code 88346 through the CMS/Other source screen for codes with Medicare utilization of 250,000 or more. The RUC noted that this service was never surveyed but is frequently reported. The specialty society added CPT code 88347 as part of this family. The RUC requested these services be surveyed for work and review the practice expense for the September 2014 RUC meeting.

In September 2014, the specialty societies indicated and the RUC agreed that CPT codes 88346 and 88347 should be referred to the October 2014 CPT Editorial Panel as the specialty society has already submitted a code change proposal. The specialty society intends on revising the vignettes and descriptors to clarify current practice.

XII. HCPAC Review Board (Tab 26)

Anthony Hamm, DC, provided the Health Care Professionals Advisory Committee Review Board report:

Excision of Nail Bed
Timothy Tillo, DPM (APMA)

In January 2014, the RUC reviewed 010-day global services (based on 2012 Medicare utilization data) and identified 18 services with >1.5 office visits and 2012 Medicare utilization data over 1,000. CPT codes 11750 and 11752 were identified by the RAW 010-day global post-operative visit screen with more than one post-op visit identified in the database. The RUC requested these services be surveyed for work and review the practice expense for the September 2014 RUC meeting.

11750 ***Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal;***
The HCPAC reviewed the survey results from 83 podiatrists. The HCPAC determined that the survey 25th percentile work RVU of 1.99 for CPT code 11750, which is 20% less than the current work RVU, is appropriate. The HCPAC compared 11750 to key

reference code 10061 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU = 2.45 and intra-service time of 25 minutes) and determined that 10061 requires more work and time. The HCPAC requested and the specialty society agreed to remove 2 minutes of pre-service evaluation time. The HCPAC referenced MPC codes 64483 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single leve*l (work RVU = 1.90) and 64479 *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single leve*l (work RVU= 2.29) and determined the survey 25th percentile work RVU of 1.99 appropriately accounts for work and time to perform this service. **The HCPAC recommends a work RVU of 1.99 for CPT code 11750.**

11752 ***Excision of nail and nail matrix, partial or complete (eg, ingrown or deformed nail), for permanent removal; with amputation of tuft of distal phalanx***
The American Podiatric Medical Association (APMA) submitted a request and the HCPAC agreed to table CPT code 11752 until the January 2015 RUC meeting. This will allow the specialties that perform this service to determine whether code 11752 should be deleted or requires some other CPT action which could include a RUC survey with all physicians and health care professionals that perform this service.

Practice Expense
The HCPAC accepted the direct practice expense inputs as approved by the PE Subcommittee.

The RUC filed the HCPAC Review Board Report.

XIII. Practice Expense Subcommittee (Tab 20)

Doctor Manaker, Chair, presented the report of the Practice Expense Subcommittee

- The Practice Expense (PE) Subcommittee reviewed the practice expense inputs for each tab and voted on and passed by the RUC
- The Relativity Assessment Workgroup (RAW) joined the PE Subcommittee to discuss two policy issues: the first of which is the issue of very expensive equipment and very expensive disposable supplies potentially creating distortions in the fee schedule, the second issue is whether or not it is appropriate to create a RAW screen to address the potential problem. This discussion began because of the PE Subcommittee's review of radiation treatment services in January 2014. These services were reviewed as potentially misvalued in large part due to the high cost of the linear accelerator, which was priced at more than $1.6 million over 15 years ago. However, the linear accelerator previously existing in the codes is no longer commercially available and the new linear accelerator is much more expensive at approximately $2.6 million. In this way, already expensive equipment PE inputs are being necessarily updated to even more costly equipment PE inputs.
- The PE Subcommittee began to question what the impact of a sudden increase in supplies and equipment when reviewing direct PE inputs actually is for potentially misvalued codes, because even if the physician work time is reduced the total RVU of the service may increase because of practice expense updates.

- Some members of the Practice Expense Subcommittee have raised concerns that due to the redistributive impacts, high cost equipment and supplies should be reviewed comprehensively, rather than piecemeal. There are a number of approaches to address this issue, some of which CMS has proposed in the past and not moved forward with. These include obtaining pricing from:

    - Other sources such as the VA or the GSA acquisition cost lists
    - Proprietary hospital acquisition cost list (unusable)
    - Both inpatient and outpatient hospital cost reports
    - Average Sales Price(ASP)/Average Wholesale Price (AWP) pricing, similar to what CMS has done for chemotherapy
    - CMS or contractor re-pricing

- Contractor re-pricing has been done at least twice in the years since the resource-based practice expense component of the RBRVS was implemented.
- Each approach has merits and drawbacks and the PE Subcommittee was not ready to take any action on the issue but wanted to get some information to inform the Subcommittee's subsequent discussions. There was reluctance around the table to implement any initial screens through the RAW regarding any practice expense issues, but it was recognized that this may be an option in the future.
- The PE Subcommittee and the RAW also made it clear that they did not want to place specialty societies at "double jeopardy". To use radiation oncology and their linear accelerator as an example, the Subcommittee did not want to ask the specialty to resurvey a code family that was recently reviewed 18 or 24 months before because of a new screen.
- After a long discussion, the PE Subcommittee ultimately decided that RUC staff will analyze the RUC database to determine the PE RVU as a percentage of the total RVU. Staff will group the codes into quartiles. For the top quartile, staff will determine if any of the codes also have supplies costing more than $500, equipment costing over $1 million, as well as display the total utilization for the code and when it was last reviewed by the PE Subcommittee. Additionally, staff will generate a total impact figure based on the PE RVU multiplied by the utilization of the code in order to capture low RVU, high volume codes. This analysis will be discussed at a future joint Relativity Assessment Workgroup (RAW)/PE Subcommittee meeting.
- The data will be reviewed at the next meeting to determine if there is a problem at all because although theoretically these high priced PE inputs appear to create distortion, it may be that they are periodically reviewed every 3-4 years and relativity across the system is maintained.
- A member of the RAW brought up that the current RAW screens do not focus on PE. Although the RAW members review PE alongside physician work, there is not a mechanism to bring attention to the PE if there are discrepancies between the two. Generally the societies do not comment on the PE component of the codes at the RAW meetings.
    - Doctor Manaker responded that many RUC participants have similar concerns and that the data should help to inform us regarding if the PE Subcommittee is reviewing the codes in question or if we are missing them. If we are missing them then we need to discuss how the PE Subcommittee can identify additional codes that need review.
    - AMA staff clarified that when codes are identified through a RAW screen, both work and practice expense are reviewed. CMS also calls for comment every year

and at times practice expense issues have been identified this way, so that is another mechanism to identify potentially misvalued services.

The RUC approved the Practice Expense Subcommittee Report

XIV. Relativity Assessment Workgroup (Tab 21)

Doctor Raphaelson provided a summary of the Relativity Assessment Workgroup meeting.

- Pre-Time Analysis Action Plans
  Doctor Raphaelson indicated that in January 2014, the RUC identified codes reviewed prior to April 2008 with pre-time greater than pre-time package 4 *Facility - Difficult Patient/Difficult Procedure* (63 minutes), the longest standardized package, for services with 2012 Medicare Utilization over 10,000. The Workgroup noted that all services were valued by magnitude estimation and therefore the readjustments in pre-service time category did not alter the work RVU. Additionally, crosswalks for each service were presented validating the pre-time recommended. The Relativity Assessment Workgroup reviewed these action plans and recommended specific adjustments. All codes were valued by magnitude estimation. Specialties provided crosswalks for all codes. In no case did the RUC recommended times that were greater than the surveyed times. RAW recommends pre-time adjustment without adjustment to the work RVUs.

  A RUC member questioned how the Workgroup determined that the work values remain valid. Doctor Peter Smith, Relativity Assessment Workgroup Vice-Chair, noted that the total pre-time did not differ that much, the Workgroup primarily moved pre-time from one category to another due to standard conventions. The pre-time intensity stayed the same at 0.0224 and therefore no change in work RVU was necessary. Doctor Smith reiterated that the work RVUs for these services were all based on magnitude estimation and comparison to codes that are correct. A change in RVU would only be necessary if there is a change in the service itself. Doctor Smith noted that the Workgroup discussed each code in which action plans were developed and explained how each was initially valued. None of the services were valued by building block.

  Doctor Raphaelson noted that the Workgroup determined that this screen was useful, however did not reveal any large outliers and therefore the utilization threshold does not need to be lowered to identify more services. The RUC recommends the following specific pre-time adjustments to align with pre-time package standards and each family of services:

CPT Code	Recommendation	Eval	Positi-oning	SDW	Total
15002	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	15	70
15004	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	15	70
15100	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	10	10	60
15240	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	3	10	53
20680	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	15	15	63

22612	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	18	15	73
23412	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	15	70
25609 25606 25607 25608	Maintain work RVU and adjust the times from pre-time package 3. Change the pre-time for codes 25606, 25607 and 25608.	33	10	15	58
27134	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	20	75
27814	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	10	15	58
29827	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	15	15	63
47562	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	10	15	58
63030	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	18	17	75
63042	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	18	20	78
93641	Maintain work RVU and adjust the times from pre-time package 2B.	33	1	5	39

- Re-Review of Flagged Services Action Plans

  The Workgroup reviewed 14 codes flagged to be re-reviewed after additional utilization data became available. The RUC recommends the following:

CPT Code	Recommendation
22214	Maintain and mark screen as complete. The continued growth represents natural growth due to aging of the population and changes in the technology and procedure itself that make it more common to use osteotomy as a treatment for conditions such as curvature of the spine and other spinal deformities. Code 22214 is a low volume procedure and as such the absolute growth in volume is very low (less than 400 additional annual Medicare utilization growth between 2008 and 2012) and steady.
22849	Maintain and mark screen as complete. Growth of 22849 has stabilized since 2011 and in fact has decreased from 4,307 in Medicare utilization to 4,155 in 2012 (preliminary CMS estimates for 2013 Medicare utilization is 4,194 so essentially no change from 2012). We anticipate this Medicare utilization to continue with virtually no growth or actual decreases as a result of the 2011 CPT changes and CPT assistant article.
22851	Survey for January 2015. Was initially identified as fastest growing and continues to grow.
26080	Maintain and mark screen as complete. A CPT Assistant article was published. Although the percentage of office based claims has decreased slightly, the absolute number of claims has not changed. Detail data do not indicate these claims are isolated to a few providers. In addition, over 30% of the office-based claims are from primary care physicians. In summary, this is a low volume code with variable post-operative care that would be unlikely (or rare) to be performed in an office setting. The AAOS and ASSH will continue to advocate correct coding through education of membership.
50605	Maintain and mark screen as complete. 2009 CPT Assistant article and CCI edits were effective, utilization is decreasing.
63056	Maintain and mark screen as complete. There have been many CPT Assistant articles since 2009 regarding code 63056, which have been effective. The October 2009 article did not address miscoding with code 62287, but resulted in stabilization / slight decrease in utilization. Another CPT Assistant was published July 2012, related to 62287 / 63056 and percutaneous versus open. This newest CPT Assistant and society education focuses on the correct coding of 63056 versus 62287.
64415	Re-review in 3 years (Sept 2017), growth of using this service for post-operative pain is expected to stop.
64445	Re-review in 3 years (Sept 2017), growth of using this service for post-operative pain is expected to stop

	decrease.
64447	Re-review in 3 years (Sept 2017), growth of using this service for post-operative pain is expected to stop.
64555	Develop CPT Assistant article to clarify the appropriate use of the code and stabilize its utilization. Review in 3 years (Sept 2017).
76940	Develop action plan for January 2015 meeting to determine whether this should be submitted to CPT for revision or resurveyed.
76948	Survey January 2015.
76965	Maintain and mark as complete. The utilization has decreased and if bundling is necessary the CPT/RUC Joint Workgroup on Bundled Services will identify.
93662	Maintain and mark as complete. The utilization is reasonable could be reviewed in the future if it is identified via other screens.

- NPRM for 2015 MPFS Action Plans

  Doctor Raphaelson summarized that in 2011, CMS identified 70 High Expenditure codes that had not been reviewed in the past five years (after 2006) and requested review. After expanding to 128 services to ensure review of families, the RUC reviewed and submitted recommendations for all of these services. In the NPRM published in July 2014, CMS repeated this "screen", resulting in 64 codes. Twenty of these 64 codes were services just reviewed by the RUC or already in the CPT process (eg, physical therapy services). The remaining 44 codes were distributed to specialty societies to develop action plans (identify families, refer to CPT, survey, other). Many of the specialties responded by objecting to the CMS request.

  The Workgroup understands that the High Expenditure list CMS developed is not an actual objective screen. Unlike CMS, the RUC has used indicators that a service may be potentially misvalued, such as site of service anomalies or a different specialty currently performing the service currently than was originally surveyed. The Workgroup also discussed the number of years since the last RUC review in which CMS established as a threshold for these high expenditure services (not RUC reviewed since 2009/5 years ago). **The Workgroup recommends that in the future CMS should consider that codes evaluated in 2009 or later should be reviewed only if it presents a specific reason to consider that the codes may be misvalued.**

  The Workgroup noted that potentially misvalued services are now nominated by CMS and the public annually instead of every five years. The Workgroup discussed the high expenditure list of codes and noted that four services were reviewed in 2009 (14060, 51728, 76536 and 78452). The Workgroup asked CMS why they used five years, rather than the previous six year timeframe. CMS staff responded that they began with 2015 (rather than 2014), resulting in any codes reviewed 2009 or prior years. This list is similar to the lists CMS previously published for every Five-Year Review in which they nominate services they would like re-examined. The Workgroup noted that although all services identified would appear on an LOI, specialty societies have options other than to survey; once on an LOI specialty societies may take a code back to CPT for revision, refer a specific request to the Research Subcommittee such as valuation by crosswalk or abbreviated survey or the society may opt not to survey a service if they do not believe

the service has changed. **The Workgroup recommends that going forward, any CMS nominated codes be placed on a Level of Interest (LOI) and not be subject to the action plan process.**

In reviewing the Workgroup report, CMS reiterated the request to review these services located in the Federal Register/Vol. 79, No. 133 /Friday, July 11, 2014 / Proposed Rules page 40337:

The Workgroup concurred that a review of the codes in Table 10 is warranted to assess changes in physician work and to update direct PE inputs since these codes have not been reviewed since CY 2009 or earlier. Furthermore, since these codes have significant impact on PFS payment at the specialty level, a review of the relativity of the codes is essential to ensure that the work and PE RVUs are appropriately relative within the specialty and across specialties, as discussed previously. For these reasons, the Workgroup is proposing the codes listed in Table 10 as potentially misvalued.

A RUC member questioned how CMS would handle it if a specialty society did not indicate interest via the LOI for services CMS has identified as potentially misvalued. CMS responded that if such services are congressionally mandated to review, the Agency would take into account any response from specialty societies, the RUC, etc and make the appropriate determinations.

The Workgroup recommended the following for the services identified by CMS:

Table 10: High Expenditure Allowed Charges > $10 million

CPT® Code	Recommendation	Code Family
11100	Survey for work and review PE January 2015.	
11101	Survey for work and review PE January 2015.	
11730	Survey for work and review PE January 2015.	
14060	Survey for work and review PE January 2015.	14061
17110	Survey for work and review PE January 2015.	17111
31575 31579	Survey for work and review PE April 2015.	31576 31577 31578
36215	Review in 3 years (Oct 2017). CPT code 36215 will be greatly impacted by the new Cervicocerebral Angiography codes, which bundle 36215 and the associated S&I code. These codes were presented at the April 2012 RUC meeting. At that time, the multispecialty group estimated that 90% of the 36215s will be coded by the newly created Cervicocerebral Angiography codes, effective January 2013. (Included in the budget neutrality calculations submitted with the RUC recommendations.) The specialty societies request that 36215 be maintained until 3 years of utilization data are available and the specialties can determine the typical vignette and dominant specialty.	
36870	Refer to CPT 2017 cycle. To bundle with frequently reported together services with 36147 (97%), 36148 (63%), and 35476 (73%) because these additional procedures are commonly required in a successful thrombectomy.	
51720	Survey for work and review PE January 2015.	

51728	Survey for work and review PE January 2015.	
51798	Survey for work and review PE January 2015.	
52000	Survey for work and review PE January 2015.	
55700	Survey for work and review PE January 2015.	
66821	Request global change from 090-day to 010-day and survey for Oct 2015 RUC meeting.	66820
67228	Request global change from 090-day to 010-day and survey for Jan 2015 RUC meeting. (Request was previously requested and denied by CMS).	67227
68761	Request global change from 010-day to 000-day and survey for Oct 2015 RUC meeting.	68760
71010	Survey for work and review PE January 2015.	
71020	Survey for work and review PE January 2015.	
71260	Survey for work and review PE January 2015.	
74183	Survey for work and review PE for October 2015.	
75978	Refer to CPT to bundle with 35476 for CPT 2017 cycle.	
76536	Survey for work and review PE January 2015.	
77263	Survey for work and review PE January 2015.	77261 77262
77334	Survey for work and review PE January 2015.	77332 77333
78452	Survey for work and review PE January 2015.	78451 78453 78454
88185	Maintain and remove from screen. Codes 88185 and 88184 were reviewed by the RUC in April 2014 through the RUC's practice expense review of potentially impacted services by CMS' OPPS/ASC payment cap proposal. Both codes are technical component add-on codes with no physician work.	
91110	Survey for work and review PE January 2015.	91111
92136	Survey for work and review PE for October 2015.	76516 76519
92250	Survey for work and review PE January 2015.	
92557	Survey for work and review PE January 2015.	92551 92552 92553 92555 92556
93280	Survey for work and review PE January 2015.	93279- 93299
93306	Survey for work and review PE January 2015.	93303 93304 93307 99308
93351	Survey for work and review PE January 2015.	93350
94010	Survey for work and review PE January 2015.	94060 94070

95004	Survey for work and review PE January 2015.	
95165	Survey for work and review PE January 2015.	95144
95957	Survey for work and review PE January 2015.	95812 95813 95816 95819 95822
96101 96118	Refer to CPT Feb 2015 and RUC review April 2015.	96102 96103 96119 96120 96125
96372	Survey for work and review PE January 2015.	
96375	Survey for work and review PE January 2015.	96374
96401	Survey for work and review PE January 2015.	
96409	Survey for work and review PE January 2015.	96411

AMA RUC staff will schedule items in a timely, but reasonable basis, when a specialty has numerous codes or families identified.

NPRM for 2015 – Potentially Misvalued Services

Issue	CPT® Code	Description of Request	Recommendation
Intravascular Ultrasound – PE Only	37250 37251	In the NPRM for 2015 MPFS a stakeholder requested that CMS establish non-facility PE RVUs for CPT code 37250 and 37251. CMS is seeking comment regarding whether it is appropriate to have non-facility PE RVUs for these codes and if so what inputs should be assigned.	Refer to CPT. A CCP was submitted for the 2014 October CPT meeting to revise these Intravascular Ultrasound codes.
Submucosal Ablation of the Tongue Base	41530	In the NPRM for 2015 MPFS CPT code 41530 was nominated for review as a potentially misvalued code. The nominator state that CPT code 41530 is misvalued because there have been changes in the PE items used in furnishing the service. The nominator specifically requested that SD109 probe be replaced with a more typically used probe, which costs less and that the replacement be used for equipment code EQ214 radiofrequency generator, to reflect a more appropriate input based on current invoices.	Remove from screen. Already addressed through the ASC/OPPS Cap review which was submitted for 2015.

Epidural Injection and Fluoroscopic Guidance	62310 62311 62318 62319 77001 77002 77003	CMS developed interim final values for 2014 for these services 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 states 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 proposes to include 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.	Refer to CPT 2017 cycle to ensure that the codes accurately describe the services.
Neurostimulator Implantation	64553 64555	A stakeholder raised questions regarding whether codes 64553 and 64555 included the appropriate direct PE inputs when furnished in the non-facility setting. It appears that these inputs have not been evaluated recently and therefore CMS are nominating these codes as potentially misvalued for the purpose of ascertaining whether or not there are non-facility direct PE inputs that are not included in the direct PE inputs that are typical supply costs for these services.	Review PE only January 2015.
Mammography	77055 77056 77057	These services were identified via the CMS/Other Source – Utilization over 250,000 screen. January 2014, both CPT codes and G codes exist to describe screening/diagnostic mammography. The RUC recommended that it analyze the screening/diagnostic mammography services G0202, G0204 and G0206 and CPT codes 77057, 77056 and 77055 in September 2014, after the Proposed Rule is released and CMS addresses the RUC recommendation to convert the direct practice expense medical supply inputs from film to digital. In the NPRM for 2015, CMS will update the direct PE inputs for all imaging codes to reflect the migration from film to digital storage technologies since digital storage is not typically used in imaging. CMS confirmed that the majority of all mammography is digital. As a result, CMS are proposing that the CPT codes 77055-77057 be used for reporting mammography to Medicare regardless of whether film or digital technology is used and to delete G0202, G0204 and G0206. CMS proposes for CY 2015, to value the CPT codes using the values established for the digital mammography G-codes since digital technology is now the typical services. In addition, since the G codes proposed to use for CY 2015 have not been reviewed since they were created in CY 2002, CMS proposed to include 77005, 77056 and 77057 to the list of potentially misvalued codes.	Survey for work and review PE for January 2015.

Abdominal Aortic Aneurysm Ultrasound Screening	G0389	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. 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 we 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, we 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 code76775, 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. after considering the issue, CMS are proposing G0389 as a potentially misvalued code and seeking recommendations regarding the appropriate inputs that should be used to develop RVUs for this code. CMS has not reviewed the inputs used to develop RVUs for this code since it was established in CY 2007 and the RVUs were directly crosswalked from 76705. Based on the issues raised by stakeholders, CMS believes that it should value this code through the standard methodologies, including the full PE RVU methodology. In order to do so, CMS are proposing to include this code on our list of proposed potentially misvalued codes and seek input from the public and other stakeholders, including the RUC, regarding the appropriate work RVU, time, and direct PE inputs that reflect the typical resources involved in furnishing the service.	Refer to CPT to transition this code to a Category I code for the 2016 cycle.

Prostate Biopsy Codes	G0416	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 have 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) represents 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 believes it would be appropriate to use only one code to report prostate biopsy pathology services. Therefore, CMS proposes to revise the descriptor for G0416 to define the service regardless of the number of specimens, and to delete codes G0417, G0418, andG0419. CMS proposes to revise G0416 for use to report all prostate biopsy pathology services, regardless of the number of specimens, because we believe this will eliminate the possible confusion caused by the coding while maintaining payment accuracy. CMS are proposing G0416 as a potentially misvalued code for CY 2015. CMS seeks public comment on the appropriate work RVUs, work time, and direct PE inputs.	Survey for work and review PE for January 2015.
Obesity Behavioral Group Counseling	G0447 GXXX2 GXXX3	CMS added coverage for a new preventative benefit, Intensive Behavioral Therapy for Obesity and created code G0447 for reporting and payment of individual behavioral counseling for obesity. CMS notes that behavioral counseling for obesity is sometimes furnished in group sessions and questions were raised about whether group sessions could be reported using G0447. To improve accuracy CMS is creating two new G codes for the reporting and payment of group behavioral counseling for obesity, GXXX2 *Face-to-face behavioral counseling for obesity, group (2-4), 30 minutes* and GXXX3 *Face-to-face behavioral counseling for obesity, group (5-10), 30 minutes*. CMS believes that the face-to-face behavioral counseling for obesity services described byGXXX2 and GXXX3 would require similar per minute work and intensity as G0447, which is a 15-minute code with a work RVU of 0.45. Therefore, to develop proposed work RVUs for codes GXXX2 and GXXX3 CMS scaled the work RVU of G0447 to reflect the differences in the codes in terms of the time period covered by the code and the typical number of beneficiaries per session. Adjusting the work RVU for the longer time of the group codes results in a work RVU of 0.90 for a 30-minute session. Since the services described by GXXX2 and GXXX3 will be billed per beneficiary receiving the service, the work RVUs and work time that we are proposing for these codes are based upon the typical number of beneficiaries per session, 4 and 9, respectively. Accordingly, CMS are proposing a work RVU of 0.23 with a work time of 8 minutes for GXXX2 and a work RVU of 0.10 with a work time of 3 minutes for GXXX3. **CMS requests public comment on the proposed values for GXXX2 and GXXX3.**	Survey for work and review PE for January 2015.

- **New Technology/New Services Review**
  The Workgroup will review the new technology/new services action plans at the January 2015 Relativity Assessment Workgroup meeting.

- **Utilization Review (CPT 2012)**
  The Workgroup will review this issue at the January 2015 Relativity Assessment Workgroup meeting. The specialties in the *Destruction of Neurolytic Agent* issue are encouraged to immediately begin addressing coding education and clarification.

- **Informational Items**
  The following reports were included as informational items:

  - Referrals to the CPT Editorial Panel
  - Referrals to the CPT Assistant Editorial Board
  - Potentially Misvalued Services Progress Report
  - Full CMS/Relativity Assessment Status Report

  The RUC approved the Relativity Assessment Workgroup Report

XV. Research Subcommittee (Tab 22)

Doctor Scott Collins, Chair, provided a summary of the Research Subcommittee report:

- **The RUC reviewed and accepted the June Research Subcommittee Online Review reports.**
- **RUC Survey Instrument and Summary of Recommendation Form- Intensity and Complexity Questions**

  The Research Subcommittee continued its ongoing discussion on the RUC survey instrument intensity and complexity (I/C) questions and data, including whether Intensity & Complexity survey questions 3-4 should be maintained, modified or deleted going forward.

  The Subcommittee agreed that they would like to maintain the overall concept of intensity and complexity and many still find these data useful when evaluating specialty society recommendations. The majority of Subcommittee members expressed their preference for improving the methodology, rather than eliminating it. Some subcommittee members also emphasized that they find each of the 8 subcomponents of question 4 very useful when evaluating specialty society recommendations which involve procedures that the RUC reviewers do not have experience in performing themselves.

  During its discussion of the analyses, the Subcommittee noted that the current Summary of Recommendation form only reports summary data from survey respondents that selected the top key reference service code, which typically is selected by less than 30 respondents and is typically selected less than 50% of the time. The Subcommittee also observed that the vast majority of survey respondents select a "3", "4" or "5" on the 5-point rating scale, while the current questions ask for the respondent to rank the survey code against the "universe of codes" that their specialty performs. Subcommittee members also shared their belief that the current method is not statistically valid.

The Research Subcommittee recommended for the RUC to require that Specialty Societies include both the top key reference code and the second highest key reference code on the Summary of Recommendation (SOR) form, including selection information and the corresponding intensity and complexity ratings. AMA staff would update the SOR form accordingly.

The Subcommittee concurred that switching the I/C questions to a true Likert scale would be beneficial and that it would improve the validity of the survey data.

The Subcommittee also agreed that instead of separately asking survey respondents to rate pre-, intra- and post-service intensity/complexity that the respondent should instead be asked to rate the intensity/complexity of all physician work they perform while providing the service. The Subcommittee noted that due to pre-service packages, the pre-service I/C question may no longer be necessary.

The Research Subcommittee recommended the following changes to the RUC Survey Instrument:

- **Switch the order of questions 3 and 4.**
- **Change the questions so they ask survey respondents to directly rate each survey code relative to its selected reference code, in place of asking the survey respondent to rate the survey code and reference code separately relative to the universe of codes the survey respondent's specialty performs.**
- **Convert both questions to a true 5-point Likert scale. Instead of a smooth 1-5 progression with no "center", the question responses were switched to "Much Less" (Identified as "-2" in raw data); "Somewhat Less" (Identified as "-1" in raw data); "Identical" (Identified as "0" in raw data); "Somewhat More" (Identified as "+1" in raw data); Much More (Identified as "+2" in raw data).**
- **Modify the pre-, intra- and post-service I/C question, to instead ask the respondent to rate overall intensity/complexity of all physician work they perform while providing the service.**

The Subcommittee also requested for AMA staff to conduct an analyses of the new data, once available. The Subcommittee would then review these analyses and determine whether the updated questions would need further modification.

The Chair of the RUC thanked the Subcommittee for its work and noted that these changes would reduce the number of ratings required of the survey respondent from 22 (11 for survey code and 11 for reference code) to 9 ratings.

- **Requirement to Present Summary Data to RUC if Survey is Conducted**

At the January 2014 RUC Meeting, a RUC member brought up a concern regarding the current ability for specialty societies to conduct a survey and then request to resurvey, without ever having to submit a summary of the original survey data to the RUC. The RUC member proposed that if a survey is conducted, then a summary of the original data would need to be submitted to the RUC. After reviewing the 12 occurrences from the past 5 years prior to the current meeting, the Subcommittee noted that it did not appear to be an endemic issue. The Subcommittee noted that the most common rationale given by societies was that they did not submit their data due to a low survey response. RUC staff

also noted that the occurrences appeared to be random, with no one specialty frequently asking to resurvey.

The Research Subcommittee does not recommend the adoption of this proposal. Instead, the Subcommittee requested for AMA staff to track the occurrences and will re-evaluate the issue in two years.

- **Other Business**

  A specialty society staffer expressed their concern that the survey instrument starts abruptly with no introductory paragraph to explain the purpose of the survey instrument or its main components. **The Subcommittee agreed that the lack of an introductory paragraph in the survey instrument was a concern and requested for AMA staff to draft a paragraph for the Subcommittee to review at the January 2015 meeting.**

  The rough schedule of the transition to the online RUC survey tool was shared as an informational item. The process continues to proceed according to plan. There is no set date for complete transition to the Qualtrics, tool though work continues in that direction.

The RUC approved the Research Subcommittee Report

XVI. Professional Liability Insurance Workgroup (Tab 23)

Doctor Lawrence Martinelli, Acting Chair, provided a summary of the Professional Liability Workgroup report:

- The Workgroup members discussed the final RUC comments to the agency regarding their revisions to the PLI RVUs and had nothing to add. **However, the members agreed that if the agency were to move forward with their proposal to transition away from surgical globals, the Workgroup would reconvene to parse through some of these more difficult issues and provide analysis to the RUC.**
- Finally, the Workgroup discussed the need for CMS to use the data that their contractor is collecting for non-MD/DO specialties rather than crosswalking them to the lowest MD specialty (Allergy/Immunology). The agency's decision to crosswalk these specialties have resulted in most of these non-MD/DO specialties receiving PLI risk factors many times above their actual practice costs. **The Workgroup reiterated that CMS should use any data that they are able to collect for these specialties to ensure accurate, fair PLI RVUs are being assigned.**

The RUC approved the Professional Liability Insurance Report

XVII. Administrative Subcommittee (Tab 24)

Doctor Michael Bishop, Chair, provided a summary of the Administrative Subcommittee report:

- **Attestation from Vendors Supplying Survey Sample**
  Doctor Bishop noted that at the January 2014 meeting, a RUC member proposed that if a targeted survey is performed using contact information provided from a company/vendor, an attestation should be required stating that the company/vendor provided no further

communication regarding valuation or reimbursement. The Administrative Subcommittee discussed this issue and recommended:

1. The RUC require attestation statements from companies/vendors attesting that they have not and will not contact potential RUC survey respondents.
2. The RUC add a question to the survey instrument for respondents to confirm that they have not received correspondence directly from the company/vendor.

AMA staff worked with the AMA Office of General Counsel and drafted a RUC Vendor/Company Attestation Statement and as well as revised the survey instrument disclosure section. **The Administrative Subcommittee reviewed the Vendor/Company Attestation and recommends the following:**

AMA/Specialty Society RVS Update Committee (RUC)
Vendor/Company Attestation Statement

This form needs to be completed by an authorized representative of any **Vendor or Company** that makes, markets or distributes a product or device utilized in performing the service being surveyed by the AMA/Specialty Society RVS Update Committee (RUC), as part of its CPT® code survey and valuation process, and which has supplied a list of users of such products or devices in connection with the survey and valuation process.

By submitting to the RUC a list of users of the undersigned's product or device as part of the RUC's CPT® code survey and valuation process, I attest that no employee, affiliate, or agent of the undersigned has contacted, and further covenant that they will not contact, any such user in connection with the survey. I hereby represent and warrant that I have the authority to sign this statement on behalf of the undersigned company and that the information herein is true and accurate. I understand that any false or inaccurate information will render the survey invalid, harming both the undersigned and the physicians who use the product or device.

Survey Instrument – Disclosure Question

The Administrative Subcommittee discussed adding a question to the survey instrument for respondents to confirm that they have not received correspondence directly from the company/vendor. **The Subcommittee recommends adding the following question to the disclosure page of the survey instrument:**

1. Have you been contacted by anyone other than your specialty society, other specialty societies sponsoring this survey (or any of their representatives) or the American Medical Association with respect to this survey?
   Yes ☐ / No ☐

The RUC's intent for adding this statement is to preclude individuals who have been inappropriately contacted from being part of the survey process.

- **Financial Disclosure**

In April 2014 a RUC member requested that the Administrative Subcommittee review the Financial Disclosure statement to identify presenters who participated in clinical trials that involve the codes under review. The Administrative Subcommittee discussed adding a statement to the financial disclosure statement and determined that it may need to be

specified if material income will directly result from the RUC recommendations or questioned if a statement is even necessary. **The Subcommittee will continue discussion of this issue at the January 2015 meeting.**

- **Financial Disclosure Review Process**
  Any Financial Disclosure Statements submitted by presenters that include a disclosure must be reviewed by a subgroup, 5 members of the Administrative Subcommittee as chosen by the Administrative Subcommittee Chair. In reviewing some recent disclosures members of the Financial Disclosure Review Workgroup requested that the Administrative Subcommittee review the Guidelines further to better define how to determine the level of conflict restrictions.

- **The RUC revised the current Financial Review Guidelines:**
  The Financial Disclosure Review Workgroup will come to consensus regarding whether any restrictions should be placed on the Advisor/Presenter's presentation to the RUC, as follows:

  1. No restriction. Advisor/Presenter may present to the full RUC.
  2. Advisor/Presenter may provide a brief (less than 5 minutes) description of how the procedure is performed. The presenter must then leave the RUC table, but may answer questions from the floor limited to the procedure itself.
  ~~3.~~ Advisor/Presenter may not present to the Practice Expense Subcommittee or the RUC ~~table or attend the RUC meeting.~~

The RUC reviewed the current financial disclosure review process and recommends if a presenter indicates that he/she receives stock options related to the specific service, he/she may not present to the Practice Expense Subcommittee or the RUC.

The RUC recommends that the Administrative Subcommittee consider conflicts for individuals that speak to issues from the audience at RUC meetings at the January 2015 meeting.

The RUC approved the Administrative Subcommittee Report

XVIII. Multispecialty Points of Comparison Workgroup (Tab 25)

Doctor George Williams, Chair, provided a summary of the Multispecialty Points of Comparison Workgroup report to the RUC.

- The MPC Workgroup members reviewed proposals from several specialties (AAN, AAP, ACR and ASHA) for codes to be added to the MPC list.

The Workgroup approves the following codes to be added to the MPC list.

CPT	Long Descriptor	Work RVU	Glob	RUC Meeting	2013 Freq	Specialty
95819	Electroencephalogram (EEG); including recording awake and asleep	1.08	XXX	Oct12	266,741	AAN (Neurology)
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	000	Apr06	198	AAP (Pediatrics)

90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	0.17	XXX	Oct09	514	AAP (Pediatrics)
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	2.00	XXX	Apr09	1	AAP (Pediatrics)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)	1.50	XXX	Oct10		AAP (Pediatrics)
99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant	1.92	XXX	Oct10	7	AAP (Pediatrics)
70460	Computed tomography, head or brain; with contrast material(s)	1.13	XXX	Oct12	35,330	ACR (Radiology)
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	2.29	XXX	Apr13	261,257	ACR (Radiology)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	1.30	XXX	Feb10	110,401	ASHA (Speech-Language)

- Finally, the Workgroup noted that the HCPAC MPC list appears to need a robust review to insure the list is up to date and effective. **The MPC Workgroup will notify the HCPAC that they should consider conducting a review of the current HCPAC MPC list.**

The RUC approved the MPC Workgroup Report

XIX. Joint RUC/CPT Moderate Sedation Workgroup (Tab 27)

Doctor Albert Bothe gave a verbal report to the RUC on the Joint RUC/CPT Moderate Sedation Workgroup. He reported that the workgroup is on track to submit a proposal to CPT on new stand-alone moderate sedation codes. The proposal will be considered at the February CPT meeting.

The RUC approved the Joint RUC/CPT Moderate Sedation Workgroup Report

XX. Global Period Workgroup Report (Tab 28)

Doctor Douglas Leahy, Acting Chair, provided a brief summary of the conference call report from July 31, 2014.

- The Global Period Workgroup was formed out of a conversation at the April 2013 RUC meeting amongst the RUC members concerning whether solutions exist which would

more accurately capture physician work in the global period. However, once CMS made their proposal to transition away from surgical globals, the Workgroup reconvened to discuss the RUC's comments to the agency.

- The Workgroup reviewed the letter and noted that there should be additional discussion around the increase in patient costs due to the necessity of co-pays for each post-operative visit. This concern was added to the RUC comment letter. Doctor Levy also explained that a large part of the discussion centered on the potential for CMS to collect data for some time to track the use of post-operative visits to ensure they are used appropriately. CPT code 99024 *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure* is currently used in large health systems and may either be used by the agency directly or as a collection tool. There is also the possibility of using a modifier, HCPCS G code or potentially linking Part A claims to monitor the use of post-operative visits.
- Finally, the Workgroup reviewed one specialty society request to change the current global of a family of codes from a 010-day to a 000-day. CPT codes 64615, 64616, 64617 were recently surveyed and the societies deemed that a post-operative visit is not typical for these services. However, CMS made them 010-day global period anyways. **Since the current work valuation for these codes does not include any post-operative visits, the Workgroup recommends that the specialty society and RUC again request that CMS adopt 000-day global periods for these three services.**

The RUC approved the Global Period Workgroup Report

Doctor Levy adjourned the meeting at 2:57pm on Saturday, September 20, 2014.

Members Present: Scott Manaker, MD, PhD, FCCP (Chair), Guy Orangio, MD (Vice Chair), Albert Bothe, MD (CPT), James Blankenship, MD, Neal Cohen, MD, Thomas Cooper, MD, David Han, MD, Timothy Laing, MD, Alan Lazaroff, MD, Geraldine B. McGinty, MD, Eileen M. Moynihan, MD, Margaret Neal, MD, Tye Ouzounian, MD, Chad Rubin, MD, John Seibel, MD, W Bryan Sims, DNP, APRN-BC, FNP, Robert Stomel, DO, Thomas J. Weida, MD

I. Medical Supplies and Equipment Pricing/Extending PE criteria to Relativity Assessment Workgroup (RAW) screens

At the April 2014 RUC meeting, the Practice Expense (PE) Subcommittee discussed the issue of new technology and changes in practice standards that impact the cost of medical supplies and equipment. As part of the misvalued code initiative, practice expense is reviewed in addition to work. Often services are captured in the high volume or high expense screens because of very expensive equipment and disposable supplies. One consequence of this review is that the cost of already high cost equipment and disposable supplies may continue to increase and the new cost will need to be articulated in updated direct practice expense inputs. One example of this situation is the PE Subcommittee's review of radiation treatment services in January 2014. These services were reviewed as potentially misvalued in large part due to the high cost of the linear accelerator. However, the linear accelerator previously existing in the codes is no longer commercially available and the new linear accelerator is much more expensive than the old equipment. In this way, already expensive equipment PE inputs are being necessarily updated to even more costly equipment PE inputs.

Some members of the Practice Expense Subcommittee have raised concerns that due to the redistributive impacts, high cost equipment and supplies should be reviewed comprehensively, rather than piecemeal. There are a number of approaches to address this issue, some of which CMS has proposed in the past and not moved forward with. These include obtaining pricing from:

- Other sources such as the VA or the GSA acquisition cost lists
- Proprietary hospital acquisition cost list (unusable)
- Both inpatient and outpatient hospital cost reports
- ASP/AWP pricing, similar to what CMS has done for chemotherapy
- CMS or contractor re-pricing

It is not within the RUC's purview to make recommendations regarding the specific cost of supplies and equipment. The only role that the RUC plays in that process now is simply to collect paid invoices from specialty society staff and to pass along those documents to CMS. It is however in the purview of the RUC to make recommendations regarding CMS methodology to obtain price information and to comment on CMS proposals to amend their current process of pricing supplies and equipment. The RUC has opposed some of the proposed solutions listed above, but nonetheless maintained that the high cost supplies and equipment should be updated on an annual basis. The PE Subcommittee determined that it was appropriate to discuss reasonable suggestions for rebasing expensive devices and expensive supplies. RUC staff researched this issue and provided a report on all CMS proposals to update pricing of clinical practice expense supply and equipment inputs, since the costs of the original PE supply and equipment inputs were determined by a CMS contractor (Abt Associates) in 1997.

At the September 2014 RUC meeting the PE Subcommittee discussed the history detailed in the report and briefly discussed CMS' work with contractors as well as their proposal to use the GSA Medical Supply Schedule/VA Federal Supply Schedule. When discussing the issue of the linear accelerator outlined above, a CMS representative made the point that the equipment included in a service does not have to be commercially available, but rather should be what is currently typically used in a nonfacility setting. Some members of the PE Subcommittee expressed concerns that updating equipment and supplies on an annual basis would put undue burden on specialties who have already had codes identified in RAW screens and have had reductions in the work component of the service. In addition they argued that just because a service has a high cost supply item or piece of equipment does not mean that the service adversely affects other services in the RBRVS, since it may be very low volume, have very little clinical staff time or have some other characteristic that neutralizes the impact of the high cost practice expense input. Finally, the PE Subcommittee discussed the impact of using separately reported J-codes for high cost supplies, but was concerned that this would create confusion regarding the equipment minutes of use by clinical staff and that it would not solve the issue of high cost supplies and equipment consuming more of the resources in a budget neutral system.

The PE Subcommittee was also scheduled to discuss the possibility of extending PE criteria to RAW screens. The Subcommittee quickly combined the two issues to determine if medical supplies and equipment pricing could be addressed by a relativity screen. Much like the current screens that the RAW conducts, a PE screen could identify any errors in relativity that has caused services to be over- or under-valued. The PE Subcommittee ultimately decided that it was premature to develop a practice expense screen and that they wanted to be careful not to incentivize using outdated devices or create a situation where the RUC is stifling the development of new technology. The Subcommittee determined that it would be more appropriate to start by reviewing data that will illuminate how high cost supplies and equipment impact the overall distribution of PE relative value units (RVUs) across the physician payment schedule. When reviewing this data it is important to keep in mind that there is not a direct correlation between the pricing of direct PE inputs and the PE RVU as the formula that CMS uses in their bottom-up methodology to derive the PE RVU also factors in the physician work RVU and the indirect practice expense, which varies based on the specialties that perform the service.

In order to better understand the financial impact of updated practice expense inputs across the entire physician payment schedule, RUC staff will query the RUC database to determine the PE RVU as a percentage of the total RVU. Staff will group the codes into quartiles. For the top quartile (76-100%), staff will determined if any of the codes also have, supplies costing more than $500, equipment costing over $1 million, as well as display the total utilization for the code and when it was last reviewed by the PE Subcommittee. Additionally, staff will generate a total impact figure based on the PE RVU multiplied by the utilization of the code in order to capture low RVU, high volume codes. This analysis will be discussed at a future joint Relativity Assessment Workgroup (RAW)/PE Subcommittee meeting.

II. Practice Expense Recommendations for CPT 2015 and CPT 2016

Tab	Title	PE Input Changes (Yes or No)
4	Transcatheter Placement of Carotid Stents	No Revisions Standard 090 Day Global
5	Transient Elastography of Liver	Approved at April 2014 PE Subcommittee Meeting
6	Sacroiliac Joint Fusion	No Revisions Standard 090 Day Global
7	Continuous Glucose Monitoring	Major Revisions
8	Instrument –Based Ocular Screening -PE Only	Minor Revisions
9	Office or Other Outpatient Observation – PE Only	Major Revisions
10	Bone Biopsy Excisional	No PE Recommendation Petition CMS to Change Global
11	Laryngoplasty	No PE Recommendation Refer to CPT
12	Laparoscopy Lymphadenectomy	Major Revisions (38570,38571) Minor Revisions (38572)
13	Hemorrhoid(s) Injection	No Revisions
14	Liver Allotransplantation	No Revisions Standard 090 Day Global
15	Dilation and Probing of Lacrimal and Nasolacrimal Duct	Major Revisions
16	Laminectomy	No Revisions Standard 090 Day Global
17	X-Ray Exams	No Revisions
18	Morphometric Analysis In Situ Hybridization for Gene Rearrangement(s)	Approved at April 2014 PE Subcommittee Meeting

Tab	Title	PE Input Changes (Yes or No)
19	Immunofluorescent Study	No PE Recommendation Refer to CPT
26	Excision of Nail Bed	Minor Revisions

AMA/Specialty Society RVS Update Committee **Tab 21**
Relativity Assessment Workgroup
September 18, 2014

Members: Doctors Marc Raphaelson (Chair), Peter Smith (Vice-Chair), Margie Andreae, Amy Aronsky, Michael Bishop, Dale Blasier, Emily Hill, PA-C, David Hitzeman, Walt Larimore, Larry Martinelli, Gregory Przybylski, Chad Rubin and Robert Zwolak.

I. Pre-Time Analysis Action Plans

In January 2014, the RUC identified codes reviewed prior to April 2008 with pre-time greater than pre-time package 4 *Facility - Difficult Patient/Difficult Procedure* (63 minutes), the longest standardized package, for services with 2012 Medicare Utilization over 10,000. The Workgroup noted that all services were valued by magnitude estimation therefore the readjustments in pre-service time category did not alter the work RVU. Additionally, crosswalks for each service were presented validating the pre-time recommended. **The Relativity Assessment Workgroup reviewed these action plans and recommends specific adjustments below. The Workgroup determined that this screen was useful, however did not reveal any large outliers and therefore the utilization threshold does not need to be lowered to identify more services.**

CPT Code	Recommendation	Eval	Positi-oning	SDW	Total
15002	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	15	70
15004	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	15	70
15100	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	10	10	60
15240	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	3	10	53
20680	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	15	15	63
22612	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	18	15	73
23412	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	15	70
25609 25606 25607 25608	Maintain work RVU and adjust the times from pre-time package 3. Change the pre-time for codes 25606, 25607 and 25608.	33	10	15	58
27134	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	15	20	75
27814	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	10	15	58
29827	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	15	15	63
47562	Maintain work RVU and adjust the times from pre-time package 3 to be consistent with pre-time packages for this family of services.	33	10	15	58
63030	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	18	17	75
63042	Maintain work RVU and adjust the times from pre-time package 4 to be consistent with pre-time packages for this family of services.	40	18	20	78
93641	Maintain work RVU and adjust the times from pre-time package 2B.	33	1	5	39

II. Re-Review of Flagged Services Action Plans

The Workgroup reviewed 14 codes flagged to be re-reviewed after additional utilization data became available. **The Workgroup recommends:**

CPT Code	Recommendation
22214	Maintain and mark screen as complete. The continued growth represents natural growth due to aging of the population and changes in the technology and procedure itself that make it more common to use osteotomy as a treatment for conditions such as curvature of the spine and other spinal deformities. Code 22214 is a low volume procedure and as such the absolute growth in volume is very low (less than 400 additional annual Medicare utilization growth between 2008 and 2012) and steady.
22849	Maintain and mark screen as complete. Growth of 22849 has stabilized since 2011 and in fact has decreased from 4,307 in Medicare utilization to 4,155 in 2012 (preliminary CMS estimates for 2013 Medicare utilization is 4,194 so essentially no change from 2012). We anticipate this Medicare utilization to continue with virtually no growth or actual decreases as a result of the 2011 CPT changes and CPT assistant article.
22851	Survey for January 2015. Was initially identified as fastest growing and continues to grow.
26080	Maintain and mark screen as complete. A CPT Assistant article was published. Although the percentage of office based claims has decreased slightly, the absolute number of claims has not changed. Detail data do not indicate these claims are isolated to a few providers. In addition, over 30% of the office-based claims are from primary care physicians. In summary, this is a low volume code with variable post-operative care that would be unlikely (or rare) to be performed in an office setting. The AAOS and ASSH will continue to advocate correct coding through education of membership.
50605	Maintain and mark screen as complete. 2009 CPT Assistant article and CCI edits were effective, utilization is decreasing.
63056	Maintain and mark screen as complete. There have been many CPT Assistant articles since 2009 regarding code 63056, which have been effective. The October 2009 article did not address miscoding with code 62287, but resulted in stabilization / slight decrease in utilization. Another CPT Assistant was published July 2012, related to 62287 / 63056 and percutaneous versus open. This newest CPT Assistant and society education focuses on the correct coding of 63056 versus 62287.
64415	Re-review in 3 years (Sept 2017), growth of using this service for post-operative pain is expected to stop.
64445	Re-review in 3 years (Sept 2017), growth of using this service for post-operative pain is expected to stop decrease.
64447	Re-review in 3 years (Sept 2017), growth of using this service for post-operative pain is expected to stop.
64555	Develop CPT Assistant article to clarify the appropriate use of the code and stabilize its utilization. Review in 3 years (Sept 2017).
76940	Develop action plan for January 2015 meeting to determine whether this should be submitted to CPT for revision or resurveyed.
76948	Survey January 2015.
76965	Maintain and mark as complete. The utilization has decreased and if bundling is necessary the CPT/RUC Joint Workgroup on Bundled Services will identify.
93662	Maintain and mark as complete. The utilization is reasonable could be reviewed in the future if it is identified via other screens.

III. NPRM for 2015 MPFS Action Plans

In 2011, CMS identified 70 High Expenditure codes that had not been reviewed in the past five years (after 2006) and requested review. After expanding to 128 services to ensure review of families, the RUC reviewed and submitted recommendations for all of these services. In the NPRM published in July 2014, CMS repeated this "screen", resulting in 64 codes. Twenty of these 64 codes were services just reviewed by the RUC or already in the CPT process (eg, physical therapy services). The remaining 44 codes were distributed to specialty societies to develop action plans (identify families, refer to CPT, survey, other). Many of the specialties responded by objecting to the CMS request.

The Workgroup understands that the High Expenditure list CMS developed is not an actual objective screen. Unlike CMS, the RUC has used indicators that something may be potentially misvalued, such as site of service anomalies or different specialty currently performing the service as originally surveyed. The Workgroup also discussed the number of years since the last RUC review in which CMS established as a threshold for these high expenditure services (not RUC reviewed since 2009/5 years ago). **The Workgroup recommends that in the future CMS should consider that codes evaluated in 2009 or later should be reviewed only if it presents a specific reason to consider that the codes may be misvalued.**

The Workgroup noted that potentially misvalued services are now nominated by CMS and the public annually instead of every five years. The Workgroup discussed the high expenditure list of codes and noted that four services were reviewed in 2009 (14060, 51728, 76536 and 78452). The Workgroup asked CMS why they used five years, rather than the previous six year timeframe. CMS staff responded that they began with 2015 (rather than 2014), resulting in any codes reviewed 2009 or prior years. This list is similar to the lists CMS previously published for every Five-Year Review in which they nominate services they would like re-examined. The Workgroup noted that although all services identified would appear on an LOI, specialty societies have options other than to survey; once on an LOI specialty societies may take a code back to CPT for revision, refer a specific request to the Research Subcommittee such as valuation by crosswalk or abbreviated survey or the society may opt not to survey a service if they do not believe the service has changed. **The Workgroup recommends that going forward, any CMS nominated codes be placed on a Level of Interest (LOI) and not be subject to the action plan process.**

CMS reiterated the request to review these services located in the Federal Register/Vol. 79, No. 133 /Friday, July 11, 2014 / Proposed Rules page 40337:

> We believe that a review of the codes in Table 10 is warranted to assess changes in physician work and to update direct PE inputs since these codes have not been reviewed since CY 2009 or earlier. Furthermore, since these codes have significant impact on PFS payment at the specialty level, a review of the relativity of the codes is essential to ensure that the work and PE RVUs are appropriately relative within the specialty and across specialties, as discussed previously. For these reasons, we are proposing the codes listed in Table 10 as potentially misvalued.

The Workgroup recommended the following for the services identified by CMS:

Table 10: High Expenditure Allowed Charges > $10 million

CPT® Code	Recommendation	Code Family
11100	Survey for work and review PE January 2015.	
11101	Survey for work and review PE January 2015.	
11730	Survey for work and review PE January 2015.	
14060	Survey for work and review PE January 2015.	14061
17110	Survey for work and review PE January 2015.	17111
31575 31579	Survey for work and review PE April 2015.	31576 31577 31578

36215	Review in 3 years (Oct 2017). CPT code 36215 will be greatly impacted by the new Cervicocerebral Angiography codes, which bundle 36215 and the associated S&I code. These codes were presented at the April 2012 RUC meeting. At that time, the multispecialty group estimated that 90% of the 36215s will be coded by the newly created Cervicocerebral Angiography codes, effective January 2013. (Included in the budget neutrality calculations submitted with the RUC recommendations.) The specialty societies request that 36215 be maintained until 3 years of utilization data are available and the specialties can determine the typical vignette and dominant specialty.	
36870	Refer to CPT 2017 cycle. To bundle with frequently reported together services with 36147 (97%), 36148 (63%), and 35476 (73%) because these additional procedures are commonly required in a successful thrombectomy.	
51720	Survey for work and review PE January 2015.	
51728	Survey for work and review PE January 2015.	
51798	Survey for work and review PE January 2015.	
52000	Survey for work and review PE January 2015.	
55700	Survey for work and review PE January 2015.	
66821	Request global change from 090-day to 010-day and survey for Oct 2015 RUC meeting.	66820
67228	Request global change from 090-day to 010-day and survey for Jan 2015 RUC meeting. (Request was previously requested and denied by CMS).	67227
68761	Request global change from 010-day to 000-day and survey for Oct 2015 RUC meeting.	68760
71010	Survey for work and review PE January 2015.	
71020	Survey for work and review PE January 2015.	
71260	Survey for work and review PE January 2015.	
74183	Survey for work and review PE for October 2015.	
75978	Refer to CPT to bundle with 35476 for CPT 2017 cycle.	
76536	Survey for work and review PE January 2015.	
77263	Survey for work and review PE January 2015.	77261 77262
77334	Survey for work and review PE January 2015.	77332 77333
78452	Survey for work and review PE January 2015.	78451 78453 78454
88185	Maintain and remove from screen. Codes 88185 and 88184 were reviewed by the RUC in April 2014 through the RUC's practice expense review of potentially impacted services by CMS' OPPS/ASC payment cap proposal. Both codes are technical component add-on codes with no physician work.	
91110	Survey for work and review PE January 2015.	91111
92136	Survey for work and review PE for October 2015.	76516 76519
92250	Survey for work and review PE January 2015.	

92557	Survey for work and review PE January 2015.	92551 92552 92553 92555 92556
93280	Survey for work and review PE January 2015.	93279- 93299
93306	Survey for work and review PE January 2015.	93303 93304 93307 99308
93351	Survey for work and review PE January 2015.	93350
94010	Survey for work and review PE January 2015.	94060 94070
95004	Survey for work and review PE January 2015.	
95165	Survey for work and review PE January 2015.	95144
95957	Survey for work and review PE January 2015.	95812 95813 95816 95819 95822
96101 96118	Refer to CPT Feb 2015 and RUC review April 2015.	96102 96103 96119 96120 96125
96372	Survey for work and review PE January 2015.	
96375	Survey for work and review PE January 2015.	96374
96401	Survey for work and review PE January 2015.	
96409	Survey for work and review PE January 2015.	96411

AMA RUC staff will schedule items in a timely, but reasonable basis, when a specialty has numerous codes or families identified.

NPRM for 2015 – Potentially Misvalued Services

Issue	CPT® Code	Description of Request	Recommendation
Intravascular Ultrasound – PE Only	37250 37251	In the NPRM for 2015 MPFS a stakeholder requested that CMS establish non-facility PE RVUs for CPT code 37250 and 37251. CMS is seeking comment regarding whether it is appropriate to have non-facility PE RVUs for these codes and if so what inputs should be assigned.	Refer to CPT. A CCP was submitted for the 2014 October CPT meeting to revise these Intravascular Ultrasound codes.
Submucosal Ablation of the Tongue Base	41530	In the NPRM for 2015 MPFS CPT code 41530 was nominated for review as a potentially misvalued code. The nominator state that CPT code 41530 is misvalued because there have been changes in the PE items used in furnishing the service. The nominator specifically requested that SD109 probe be replaced with a more typically used probe, which costs less and that the replacement be used for equipment code EQ214 radiofrequency generator, to reflect a more appropriate input based on current invoices.	Remove from screen. Already addressed through the ASC/OPPS Cap review which was submitted for 2015.

Epidural Injection and Fluoroscopic Guidance	62310 62311 62318 62319 77001 77002 77003	CMS developed interim final values for 2014 for these services 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 states 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 proposes to include 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.	Refer to CPT 2017 cycle to ensure that the codes accurately describe the services.
Neurostimulator Implantation	64553 64555	A stakeholder raised questions regarding whether codes 64553 and 64555 included the appropriate direct PE inputs when furnished in the non-facility setting. It appears that these inputs have not been evaluated recently and therefore CMS are nominating these codes as potentially misvalued for the purpose of ascertaining whether or not there are non-facility direct PE inputs that are not included in the direct PE inputs that are typical supply costs for these services.	Review PE only January 2015.
Mammography	77055 77056 77057	These services were identified via the CMS/Other Source – Utilization over 250,000 screen. January 2014, both CPT codes and G codes exist to describe screening/diagnostic mammography. The RUC recommended that it analyze the screening/diagnostic mammography services G0202, G0204 and G0206 and CPT codes 77057, 77056 and 77055 in September 2014, after the Proposed Rule is released and CMS addresses the RUC recommendation to convert the direct practice expense medical supply inputs from film to digital. In the NPRM for 2015, CMS will update the direct PE inputs for all imaging codes to reflect the migration from film to digital storage technologies since digital storage is not typically used in imaging. CMS confirmed that the majority of all mammography is digital. As a result, CMS are proposing that the CPT codes 77055-77057 be used for reporting mammography to Medicare regardless of whether film or digital technology is used and to delete G0202, G0204 and G0206. CMS proposes for CY 2015, to value the CPT codes using the values established for the digital mammography G-codes since digital technology is now the typical services. In addition, since the G codes proposed to use for CY 2015 have not been reviewed since they were created in CY 2002, CMS proposed to include 77005, 77056 and 77057 to the list of potentially misvalued codes.	Survey for work and review PE for January 2015.

Abdominal Aortic Aneurysm Ultrasound Screening	G0389	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. 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 we 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, we 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 code76775, 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. after considering the issue, CMS are proposing G0389 as a potentially misvalued code and seeking recommendations regarding the appropriate inputs that should be used to develop RVUs for this code. CMS has not reviewed the inputs used to develop RVUs for this code since it was established in CY 2007 and the RVUs were directly crosswalked from 76705. Based on the issues raised by stakeholders, CMS believes that it should value this code through the standard methodologies, including the full PE RVU methodology. In order to do so, CMS are proposing to include this code on our list of proposed potentially misvalued codes and seek input from the public and other stakeholders, including the RUC, regarding the appropriate work RVU, time, and direct PE inputs that reflect the typical resources involved in furnishing the service.	Refer to CPT to transition this code to a Category I code for the 2016 cycle.

Prostate Biopsy Codes	G0416	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 have 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) represents 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 believes it would be appropriate to use only one code to report prostate biopsy pathology services. Therefore, CMS proposes to revise the descriptor for G0416 to define the service regardless of the number of specimens, and to delete codes G0417, G0418, andG0419. CMS proposes to revise G0416 for use to report all prostate biopsy pathology services, regardless of the number of specimens, because we believe this will eliminate the possible confusion caused by the coding while maintaining payment accuracy. CMS are proposing G0416 as a potentially misvalued code for CY 2015. CMS seeks public comment on the appropriate work RVUs, work time, and direct PE inputs.	Survey for work and review PE for January 2015.
Obesity Behavioral Group Counseling	G0447 GXXX2 GXXX3	CMS added coverage for a new preventative benefit, Intensive Behavioral Therapy for Obesity and created code G0447 for reporting and payment of individual behavioral counseling for obesity. CMS notes that behavioral counseling for obesity is sometimes furnished in group sessions and questions were raised about whether group sessions could be reported using G0447. To improve accuracy CMS is creating two new G codes for the reporting and payment of group behavioral counseling for obesity, GXXX2 *Face-to-face behavioral counseling for obesity, group (2-4), 30 minutes* and GXXX3 *Face-to-face behavioral counseling for obesity, group (5-10), 30 minutes*. CMS believes that the face-to-face behavioral counseling for obesity services described byGXXX2 and GXXX3 would require similar per minute work and intensity as G0447, which is a 15-minute code with a work RVU of 0.45. Therefore, to develop proposed work RVUs for codes GXXX2 and GXXX3 CMS scaled the work RVU of G0447 to reflect the differences in the codes in terms of the time period covered by the code and the typical number of beneficiaries per session. Adjusting the work RVU for the longer time of the group codes results in a work RVU of 0.90 for a 30-minute session. Since the services described by GXXX2 and GXXX3 will be billed per beneficiary receiving the service, the work RVUs and work time that we are proposing for these codes are based upon the typical number of beneficiaries per session, 4 and 9, respectively. Accordingly, CMS are proposing a work RVU of 0.23 with a work time of 8 minutes for GXXX2 and a work RVU of 0.10 with a work time of 3 minutes for GXXX3. **CMS requests public comment on the proposed values for GXXX2 and GXXX3.**	Survey for work and review PE for January 2015.

IV. New Technology/New Services Review

The Workgroup will review the new technology/new services action plans at the January 2015 Relativity Assessment Workgroup meeting.

V. Utilization Review (CPT 2012)

The Workgroup will review this issue at the January 2015 Relativity Assessment Workgroup meeting. The specialties in the Destruction of Neurolytic Agent issue are encouraged to immediately begin addressing coding education and clarification.

VI. Informational Items

- Referrals to the CPT Editorial Panel
- Referrals to the CPT Assistant Editorial Board
- Potentially Misvalued Services Progress Report
- Full CMS/Relativity Assessment Status Report

AMA/Specialty Society RVS Update Committee **Tab 22**
Research Subcommittee
September 18, 2014

Members Present**:** Scott Collins, MD (Chair), M. Douglas Leahy, MD (Vice Chair), James Georgoulakis, PhD, JD, David Hitzeman, DO, Charles Koopmann, Jr, MD, Walt Larimore, MD, Lawrence Martinelli, MD, Christopher Senkowski, MD, Peter Smith, MD, Samuel D. Smith, MD, Stanley W. Stead, MD, MBA, George Williams, MD

I. Research Subcommittee June 2014 Meeting Report

The Research Subcommittee report from the June 2014 Online Review is included in Tab 22 of the September 2014 agenda materials for approval by the RUC.

II. RUC Survey- Intensity and Complexity Questions

The Research Subcommittee continued its ongoing discussion on survey intensity and complexity (I/C) questions and data, including whether I/C survey questions 3-4 should be maintained, modified or deleted going forward. The Subcommittee had a robust dialogue on the usefulness of these questions/data and on how to proceed. Several subcommittee members acknowledged that these questions in their current form have the potential to overwhelm survey respondents at the end of a survey, reducing the overall number of survey responses.

The RUC survey instrument first included intensity and complexity questions for the first five-year review, though at the time, only asked survey respondents to rate intensity/complexity on a 5 point rating scale for three question components for the survey code and the reference code: mental effort and judgment, technical skill and physical effort, and psychological stress. In September 1997, the Research Subcommittee recommended to expand the intensity questions into their current form of 11 question components for the survey code and the reference code.

As part of its deliberation, the Subcommittee reviewed data analyses provided by AMA Staff on key reference service (KRS) selection and the distribution of I/C ratings. These analyses included the following key points:

Key Points of I/C Analyses by AMA staff (RUC-reviewed codes for CPT 2015; 247 codes)

- *% of respondents that selected the top KRS (median): 32%*
- *% of respondents that selected the top KRS (75th percentile): 46%*
- *Number of respondents that selected the top KRS (median): 17*
- *Number of respondents that selected the top KRS (75th percentile): 26*
- *I/C ratings for intra-service period component of question 4 (other I/C components had similar results)*
    - *Percentage with I/C rating greater than 3.00 (Survey code): 91%*
    - *The rating of the survey code was higher than the reference code 79 percent of the time.*
    - *Median I/C Rating (Survey Code): 3.85*
    - *Median I/C Rating (Reference Code): 3.60*

During its discussion of the analyses, the Subcommittee noted that the current Summary of Recommendation form only reports summary data from survey respondents that selected the top key reference service code, which typically is selected by less than 30 respondents and is typically selected less than 50% of the time. The Subcommittee also observed that the vast majority of survey respondents select a "3", "4" or "5" on the 5-point rating scale, while the current questions ask for the respondent to rank the survey code against the "universe of codes" that their specialty performs. Subcommittee members also shared their belief that the current method is not statistically valid.

The Research Subcommittee recommends for the RUC to require that Specialty Societies include both the top key reference code and the second highest key reference code on the Summary of Recommendation (SOR) form, including selection information and the corresponding intensity and complexity ratings. AMA staff would update the SOR form accordingly.

Many Subcommittee members expressed they would like to maintain the overall concept of intensity and complexity and still find these data useful when evaluating specialty society recommendations. The majority of Subcommittee members expressed their preference for improving the methodology, rather than eliminating it. Some subcommittee members also emphasized that they find each of the 8 subcomponents of question 4 very useful when evaluating specialty society recommendations which involve procedures that the RUC reviewers do not have experience in performing themselves.

Several subcommittee members also stated that they believe that having survey respondents review both the I/C questions and background definitions helps to appropriately prepare survey respondents to use magnitude estimation when estimating physician work later in the survey.

The Chair and other Subcommittee members expressed their interest in switching the questions to a true Likert scale. The Subcommittee agreed that this change would improve the validity of the survey data.

One Subcommittee member recommended that instead of separately asking survey respondents to rate pre-, intra- and post-service intensity/complexity, that the respondent should instead be asked to rate the intensity/complexity of all physician work they perform while providing the service. Several members expressed their support, elaborating that due to pre-service packages, the pre-service I/C question may no longer be necessary,.

The Subcommittee vote to keep the intensity and complexity questions in some fashion overwhelmingly passed.

The Subcommittee considered proposals to update the Survey instrument and recommends the following updates:

- **Switch the order of questions 3 and 4.**
- **Change the questions so they ask survey respondents to directly rate each survey code relative to its selected reference code, in place of asking the survey respondent to rate the survey code and reference code separately relative to the universe of codes the survey respondent's specialty performs.**
- **Convert both questions to a true 5-point Likert scale (e.g. instead of a smooth 1-5 progression with no "center", the questions would switch to something similar to "much less", "somewhat less", "identical", "somewhat more", "much more").**

- **Modify the pre-, intra- and post-service I/C question, to instead ask the respondent to rate overall intensity/complexity of all physician work they perform while providing the service.**

If these changes are approved by the RUC, the Subcommittee also requested for AMA staff to conduct an analyses of the new data, once available. The Subcommittee would then review these analyses and determine whether the updated questions needed further modification.

Following the Subcommittee meeting, the Chair and RUC staff drafted updated survey questions which incorporate all Research recommendations in order to assist the RUC in its review and deliberation (Addenda A). Note, that these changes would reduce the number of ratings required of the survey respondent from 22 (11 for survey code and 11 for reference code) to 9 ratings.

III. Requirement to Present Summary Data to RUC if Survey is Conducted- Discussion

At the January 2014 RUC Meeting, a RUC member brought up a concern regarding the current ability for specialty societies to conduct a survey and then request to resurvey, without ever having to submit a summary of the original survey data to the RUC. The RUC member proposed that if a survey is conducted, then a summary of the original data would need to be submitted to the RUC. The RUC referred the proposal to the April 2014 Research Subcommittee meeting.

At the April meeting, the Subcommittee members agreed that it would be useful to review all the specialty society requests to delay the survey of codes over the past five years and determine the stated reasons for these requests.

After reviewing the 12 occurrances from the past 5 years prior to the current meeting, the Subcommittee noted that it did not appear to be an endemic issue. The Chair noted that the most common rationale given by societies was that they did not submit their data due to a low survey response. RUC staff also noted that the occurrences appeared to be random, with no one specialty frequently asking to resurvey.

The Research Subcommittee does not recommend the adoption of this proposal. Instead, the Subcommittee requested for AMA staff to track the occurrences and will re-evaluate the issue in two years.

IV. Other Business

A specialty society staffer expressed their concern that the survey instrument starts abruptly with no introductory paragraph to explain the purpose of the survey instrument or its main components. T**he Subcommittee agreed that the lack of an introductory paragraph in the survey instrument was a concern and requested for AMA staff to draft a paragraph for the Subcommittee to review at the January 2015 meeting.**

RUC Survey – Transition to the Online RUC Survey Tool (*Informational Only*)

Overview of Updates to RUC Online Survey Tool and Process since April 2014

The Chair noted that an updated online survey timeline as well as an overview of updates to the online tool are provided in the agenda packet. It was noted that AMA staff are continuing to solicit feedback from specialty society staff utilizing Qualtrics. As of today, over 25 societies have utilized this free online tool (12 societies for the current meeting). The feedback has resulted in editorial design/content improvements. The Research Subcommittee will be asked to review only significant staff suggestions at a future RUC meeting.

ADDENDA A: Draft Update of Intensity and Complexity Questions and Section of SOR

Background for Question 3

In evaluating the work of a service, it is helpful to identify and think about each of the components of a particular service. Focus only on the work that you perform during each of the identified components. The descriptions below are general in nature. Within the broad outlines presented, please think about the specific services that you provide.

Physician work includes the following**:**

Time it takes to perform the service.

Mental effort and judgment necessary with respect to the amount of clinical data that needs to be considered, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.

Technical Skill required with respect to knowledge, training and actual experience necessary to perform the service.

Physical effort can be compared by dividing services into tasks and making the direct comparison of tasks. In making the comparison, it is necessary to show that the differences in physical effort are not reflected accurately by differences in the time involved; if they are, considerations of physical effort amount to double counting of physician work in the service.

Psychological stress – Two kinds of psychological stress are usually associated with physician work. The first is the pressure involved when the outcome is heavily dependent upon skill and judgment and an adverse outcome has serious consequences. The second is related to unpleasant conditions connected with the work that are not affected by skill or judgment. These circumstances would include situations with high rates of mortality or morbidity regardless of the physician's skill or judgment, difficult patients or families, or physician physical discomfort. Of the two forms of stress, only the former is fully accepted as an aspect of work; many consider the latter to be a highly variable function of physician personality.

Question 3

Rate the TYPICAL intensity of each component listed below for the survey code(s), relative to the corresponding reference service you selected for each survey code. (Rating Scale: Much Less, Somewhat Less, Identical, Somewhat More, Much More).

For example, if the average intensity for the survey code is somewhat less intense compared to the corresponding reference code, select "somewhat less" in the dropdown box below.

To view the descriptor for the** survey code(s) and reference code(s), **place your cursor over the**  **symbol located next to the code number.

Mental effort and judgment

Survey Code XXXX1 

Relative to

Selected Reference Code YYYY1 

The range of possible diagnoses and/or management options that must be considered	Much Less *(Identified as "-2" in raw data)* Somewhat Less *(Identified as "-1" in raw data)* Identical *(Identified as "0" in raw data)* Somewhat More *(Identified as "+1" in raw data)* Much More *(Identified as "+2" in raw data)*
The amount and/or complexity of medical records, diagnostic tests, or other information that must be analyzed	Much Less *(Identified as "-2" in raw data)* Somewhat Less *(Identified as "-1" in raw data)* Identical *(Identified as "0" in raw data)* Somewhat More *(Identified as "+1" in raw data)* Much More *(Identified as "+2" in raw data)*
Urgency of medical decision making	Much Less *(Identified as "-2" in raw data)* Somewhat Less *(Identified as "-1" in raw data)* Identical *(Identified as "0" in raw data)* Somewhat More *(Identified as "+1" in raw data)* Much More *(Identified as "+2" in raw data)*

Technical skill/physical effort

Survey Code XXXX1

Relative to

Selected Reference Code YYYY1

Technical skill required	Much Less *(Identified as "-2" in raw data)* Somewhat Less *(Identified as "-1" in raw data)* Identical *(Identified as "0" in raw data)* Somewhat More *(Identified as "+1" in raw data)* Much More *(Identified as "+2" in raw data)*
Physical effort required	Much Less *(Identified as "-2" in raw data)* Somewhat Less *(Identified as "-1" in raw data)* Identical *(Identified as "0" in raw data)* Somewhat More *(Identified as "+1" in raw data)* Much More *(Identified as "+2" in raw data)*

Psychological stress

Survey Code XXXX1

Relative to

Selected Reference Code YYYY1

The risk of significant complications, morbidity and/or mortality	Much Less *(Identified as "-2" in raw data)* Somewhat Less *(Identified as "-1" in raw data)* Identical *(Identified as "0" in raw data)* Somewhat More *(Identified as "+1" in raw data)* Much More *(Identified as "+2" in raw data)*
Outcome depends on skill and judgment of physician	Much Less *(Identified as "-2" in raw data)* Somewhat Less *(Identified as "-1" in raw data)* Identical *(Identified as "0" in raw data)* Somewhat More *(Identified as "+1" in raw data)* Much More *(Identified as "+2" in raw data)*

Estimated risk of malpractice suit with poor outcome	Much Less *(Identified as "-2" in raw data)* Somewhat Less *(Identified as "-1" in raw data)* Identical *(Identified as "0" in raw data)* Somewhat More *(Identified as "+1" in raw data)* Much More *(Identified as "+2" in raw data)*

Question 4

Rate the TYPICAL intensity/complexity of all physician work you perform for the survey code(s), relative to the corresponding reference service you selected for each survey code. (Rating Scale: Much Less, Somewhat Less, Identical, Somewhat More, Much More).

For example, if the overall average intensity/complexity for the survey code is somewhat more intense/complex compared to the corresponding reference code, select "somewhat more" in the dropdown box below.

To view the descriptor for the** survey code(s) and reference code(s), **place your cursor over the**  **symbol located next to the code number.

Survey Code XXXX1 

Relative to

Selected Reference Code YYYY1 

Overall Intensity/Complexity for all physician work you perform for the service	Much Less *(Identified as "-2" in raw data)* Somewhat Less *(Identified as "-1" in raw data)* Identical *(Identified as "0" in raw data)* Somewhat More *(Identified as "+1" in raw data)* Much More *(Identified as "+2" in raw data)*

Example of Updated Summary of Recommendation Form

Intensity/Complexity Rating Scale: -2= Much Less Intense/Complex, -1= Somewhat Less Intense/Complex, 0= Identical Intensity/Complexity, 1= Somewhat More Intense/Complex and 2=Much More Intense/Complex

INTENSITY/COMPLEXITY MEASURES (Mean)	**(Of those that selected the corresponding Key Reference Code)**	
Mental Effort and Judgment (Mean)	**Survey Code Relative to Key Reference Code 1 (Top KRS)**	**Survey Code Relative to Key Reference Code 2 (2nd highest KRS)**
The number of possible diagnosis and/or the number of management options that must be considered	0.01	-1.43
The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be reviewed and analyzed	-0.84	-0.09
Urgency of medical decision making	0.13	1.38
Technical Skill/Physical Effort (Mean)		
Technical skill required	1.13	1.85
Physical effort required	0.45	0.53
Psychological Stress (Mean)		
The risk of significant complications, morbidity and/or mortality	-2.00	-1.12
Outcome depends on the skill and judgment of physician	2.00	1.38
Estimated risk of malpractice suit with poor outcome	0.98	1.44

OVERALL INTENSITY/COMPLEXITY	**Survey Code Relative to Key Reference Code 1 (Top KRS)**	**Survey Code Relative to Key Reference Code 2 (2nd highest KRS)**
Time Segments (Mean)		
Overall (pre-, intra-, post-) intensity/complexity	-1.75	-1.11

AMA/Specialty Society RVS Update Committee **Tab 23**
Professional Liability Insurance Workgroup
September 19, 2014

Members: Members: Lawrence Martinelli (Acting Chair), Thomas Cooper, Stephen Kamenetzky, Charles Koopmann, Robert Kossmann, M. Douglas Leahy, James Levett, Sandra Reed, David Regan, Seth Rubenstein, G. Edward Vates

I. Review/Approval of July 22, 2014 Workgroup conference call report

The workgroup members reviewed the conference call report from July 22, 2014 and approved it without modification.

II. Review of final RUC Comment Letter relating to PLI issues

The PLI Workgroup discussed several key elements from the RUC comment letter related to PLI. First, AMA staff noted that there was one comment that was submitted to CMS that was not discussed by the Workgroup on the July conference call. The issue was that CMS should move away from the Five-Year review of PLI RVUs and move towards a yearly (i.e. rolling) review of PLI RVUs. This would have two primary advantages. First, it would base PLI RVUs on the most accurate premium rates available. Second, it would provide an avenue for specialty societies to submit comments yearly when potential issues with PLI may arise. The Workgroup members were supportive of this comment. There was discussion that certain specialties, more than other, see PLI premium rate fluctuations and will certainly benefit from a more rigorous, yearly update process. The members noted that this would be a fairer methodology for all interested stakeholders.

The Workgroup also discussed the issues surrounding the CMS proposal to eliminate the 010 and 090 day global periods as it relates to PLI RVUs. The members discussed that while it is clear that the post-operative work performed in the hospital would have clear distinctions between performing specialties, it is harder to parse out the work differences when the post-operative work is done in the office setting. **The members agreed that if the agency were to move forward with proposal, the Workgroup would reconvene to parse through some of these more difficult issues and provide analysis to the RUC.**

Finally, the Workgroup discussed the need for CMS to use the data that their contractor is collecting for non-MD/DO specialties rather than crosswalking them to the lowest MD specialty (Allergy/Immunology). The agency's decision to crosswalk these specialties has resulted in most of these non-MD/DO specialties receiving PLI risk factors many times above their actual practice costs. **The Workgroup reiterated that CMS should use any data that they are able to collect for these specialties to ensure accurate, fair PLI RVUs are being assigned.**

III. Further Business/Consideration of future analysis

No further business was discussed.

AMA/Specialty Society RVS Update Committee **Tab 24**
Administrative Subcommittee Report
September 19, 2014

Members: Doctors Michael Bishop (Chair), Margie Andreae, Dale Blasier, Ronald Burd, Anthony Hamm, DC, Adam Weinstein, J. Leonard Lichtenfeld, William Mangold, Jr., Greg Przybylski, Joseph Schlecht and James Waldorf.

I. Attestation from Vendors Supplying Survey Sample

At the January 2014 meeting, a RUC member proposed that if a targeted survey is utilized using contact information provided from a company/vendor, an attestation should be required stating that the company/vendor provided no further communication regarding valuation or reimbursement. The Administrative Subcommittee discussed this issue and recommended:

1. The RUC require attestation statements from companies/vendors attesting that they have not and will not contact potential RUC survey respondents.
2. The RUC add a question to the survey instrument for respondents to confirm that they have not received correspondence directly from the company/vendor.

AMA staff worked with the AMA Office of General Counsel and drafted a RUC Vendor/Company Attestation Statement and as well as revised the survey instrument disclosure section. **The Administrative Subcommittee reviewed the Vendor/Company Attestation and recommends the following:**

AMA/Specialty Society RVS Update Committee (RUC)
Vendor/Company Attestation Statement

This form needs to be completed by an authorized representative of any **Vendor or Company** that makes, markets or distributes a product or device utilized in performing the service being surveyed by the AMA/Specialty Society RVS Update Committee (RUC), as part of its CPT® code survey and valuation process, and which has supplied a list of users of such products or devices in connection with the survey and valuation process.

By submitting to the RUC a list of users of the undersigned's product or device as part of the RUC's CPT® code survey and valuation process, I attest that no employee, affiliate, or agent of the undersigned has contacted, and further covenant that they will not contact, any such user in connection with the survey. I hereby represent and warrant that I have the authority to sign this statement on behalf of the undersigned company and that the information herein is true and accurate. I understand that any false or inaccurate information will render the survey invalid, harming both the undersigned and the physicians who use the product or device.

Survey Instrument – Disclosure Question

The Administrative Subcommittee discussed adding a question to the survey instrument for respondents to confirm that they have not received correspondence directly from the company/vendor. **The Subcommittee recommends adding the following question to the disclosure page of the survey instrument:**

1. Have you been contacted by anyone other than your specialty society, other specialty societies sponsoring this survey (or any of their representatives) or the American Medical Association with respect to this survey?
   Yes ☐ / No ☐

The Subcommittee's intent for adding this statement is to preclude individuals from being part of the survey process.

II. Financial Disclosure

In April 2014 a RUC member requested that the Administrative Subcommittee review the Financial Disclosure statement to identify presenters who participated in clinical trials that involve the codes under review. The Administrative Subcommittee discussed adding a statement to the financial disclosure statement and determined that it may need to be specified if material income will directly result from the RUC recommendations or questioned if a statement is even necessary. **The Subcommittee will continue discussion of this issue at the January 2015 meeting.**

III. Financial Disclosure Review Process

Any Financial Disclosure Statements submitted by presenters that include a disclosure must be reviewed by a subgroup, 5 members of the Administrative Subcommittee as chosen by the Administrative Subcommittee Chair. In reviewing some recent disclosures members of the Financial Disclosure Review Workgroup requested that the Administrative Subcommittee review the Guidelines further to better define how to determine the level of conflict restrictions.

The RUC revised the current Financial Review Guidelines:

The Financial Disclosure Review Workgroup will come to consensus regarding whether any restrictions should be placed on the Advisor/Presenter's presentation to the RUC, as follows:

1. No restriction. Advisor/Presenter may present to the full RUC.
2. Advisor/Presenter may provide a brief (less than 5 minutes) description of how the procedure is performed. The presenter must then leave the RUC table, but may answer questions from the floor limited to the procedure itself.
3. ~~3.~~ Advisor/Presenter may not present to the Practice Expense Subcommittee or the RUC ~~table or attend the RUC meeting.~~

The RUC reviewed the current financial disclosure review process and recommends if a presenter indicates that he/she receives stock options related to the specific service, he/she may not present to the Practice Expense Subcommittee or the RUC.

The RUC recommends that the Administrative Subcommittee consider conflicts for individuals that speak to issues from the audience at RUC meetings at the January 2015 meeting.

IV. Financial Disclosure Review – Tab 8 Instrument Based Ocular Screening (PE Only)

The Administrative Subcommittee filed the Financial Disclosure review report as recommended by the Financial Disclosure Review Workgroup. The RUC Financial Disclosure Review Workgroup discussed the disclosure and voted that Doctor Silbert may provide a brief (less than 5 minutes) description of how the procedure is performed. The presenter must then leave the RUC table, but may answer questions from the floor limited to the procedure itself.

AMA/Specialty Society RVS Update Committee **Tab 25**
MPC Workgroup
September 19, 2014

Members: Members: George Williams (Chair), Geraldine McGinty (Vice Chair), Ron Burd, Scott Collins, James Gajewski, J. Leonard Lichtenfeld, Stanley Stead, James Waldorf, Jane White

I. Chair review of Workgroup revision process

The MPC Workgroup members reviewed proposals from several specialties for codes to be added to the MPC list. Representatives from four specialty societies (AAN, AAP, ACR, ASHA) attended the meeting to provide clarity and answer questions from workgroup members. The workgroup members also noted that specialty societies should be encouraged to take full advantage of the MPC review process to both add new services and remove services that are no longer appropriate for the list.

II. Review of specialty code recommendations

CPT	Long Descriptor	Work RVU	Glob	RUC Meeting	2013 Freq	Specialty
95819	Electroencephalogram (EEG); including recording awake and asleep	1.08	XXX	Oct12	266,741	AAN (Neurology)
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block	1.90	000	Apr06	198	AAP (Pediatrics)
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered	0.17	XXX	Oct09	514	AAP (Pediatrics)
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	2.00	XXX	Apr09	1	AAP (Pediatrics)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)	1.50	XXX	Oct10		AAP (Pediatrics)
99460	Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant	1.92	XXX	Oct10	7	AAP (Pediatrics)
70460	Computed tomography, head or brain; with contrast material(s)	1.13	XXX	Oct12	35,330	ACR (Radiology)
72158	Magnetic resonance (eg, proton) imaging, spinal canal and contents, without contrast material, followed by contrast material(s) and further sequences; lumbar	2.29	XXX	Apr13	261,257	ACR (Radiology)
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	1.30	XXX	Feb10	110,401	ASHA (Speech-Language)

After having reviewed the ASHA requested CPT code 92507, there was a consensus amongst the Workgroup members that the HCPAC MPC list appears to need a robust review, akin to what occurred to the MPC list a few years back. **The MPC Workgroup will notify the HCPAC that they should consider conducting a review of the current HCPAC MPC list.**

The Workgroup members also had significant discussion regarding concerns related to the AAP's request to include three services (99469, 99471 and 99477) which are per day, bundled services. The members were concerned that these codes would be difficult to compare across specialties due to the nature of the services. These three codes have work RVUs which are comparable to surgical services on the MPC list and could cause confusion to other specialties that may use these codes as MPC comparators. **Therefore, the Workgroup recommends that these three codes not be added and tabled until further discussion and review can be conducted.**

III. Further Business

No further business was discussed.

Members: William Mangold, MD (Chair), Anthony Hamm, DC (Co-Chair), Jane White, PhD, RD, FADA (Alt. Co-Chair), Scott Collins, MD, Leisha Eiten, AuD, CCC-A, Charles Fitzpatrick, OD, Mary Foto, OTR, James Georgoulakis, PhD, Emily Hill, PA-C, Eileen Moynihan, MD, Dee Adams Nikjeh, PhD, CCC-SLP, W Bryan Sims, DNP, APRN-BC, FNP, Timothy Tillo, DPM and Doris Tomer, LCSW

Member not present: Stephen Levine, PT, DPT, MSHA

I. Introduction and CMS Update

Doctor Edith Hambrick from CMS attended the HCPAC meeting and noted CMS is currently working on finalizing the CY 2015 Final Rule.

II. CMS Request/Relativity Assessment Identified Codes

Excision of Nail Bed (CPT Codes 11750, 11752)
American Podiatric Medical Association

Tim Tillo, DPM, representing the APMA, stated code 11750 was identified by the RAW 010-day global post-operative visit screen with more than one post-op visit in the database. The RUC requested that these services be reviewed for work and practice expense for the September 2014 meeting. Dr. Tillo reported that the APMA submitted a work recommendation of 1.99 for CPT code 11750 which is the survey 25th percentile and is 20% less than the current work RVU.

The HCPAC compared 11750 to key reference code 10061 - *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level* (work RVU = 2.45 and intra-service time of 25 minutes) and determined that 10061 required more work and time. The HCPAC requested and the specialty society agreed to remove 2 minutes of pre-service evaluation time. The HCPAC referenced MPC codes 64483- *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single leve*l (work RVU = 1.90) and 64479 - *Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single leve*l (work RVU= 2.29) and determined the survey 25th percentile work RVU of 1.99 appropriately accounted for work and time to perform this service.

The HCPAC recommends a work RVU of 1.99 for CPT code 11750.

The HCPAC accepted the direct practice expense inputs as approved by the PE Subcommittee.

11752
APMA submitted a request and the HCPAC agreed to table CPT code 11752 until the January 2015 RUC meeting. This will allow APMA to discuss with other specialties that perform this service, whether code 11752 should be deleted or some other CPT action or RUC survey with all groups.

III. New Business

Dee Adams Nikjeh, PhD, CCC-SLP, from ASHA reported that many of the HCPAC members met yesterday at an informal luncheon to discuss their role in the development of new payment models that may be proposed to CMMI by the AMA. The members of the HCPAC want to make sure that their role in the healthcare continuum is acknowledged and that they have a seat at the table as the strategies/proposals are developed.

Jane White reported that in addition to the informal lunch that several HCPAC members met with Harold Miller yesterday. The purpose of the meeting was to inform him of the role that the HCPAC plays in the current RUC process and to offer their expertise as he continues his work with AMA. Jane White mentioned that she believed that the tenor of the meeting was favorable and he was happy to accept input from the HCPAC organizations.

The discussion then focused on how HCPAC can stay informed on issues and to make sure that they are included on development of new payment models and/or strategy moving forward. One suggestion that was discussed was the development of an LOI type process to gauge interest among both physician and non-physician groups as these issues arise for example, all organizations should be solicited for interest in the stroke payment model, if that model progresses in discussion/formulation. Overall the HCPAC agreed that this will be an ongoing topic of discussion and any organization interested in meeting informally or formally at RUC meetings with other organizations may contact AMA RUC staff for assistance in coordination.

AMA/Specialty Society RVS/Update Committee
Global Period Workgroup
NPRM CMS Global Period Proposal - Conference Call Report
July 31, 2014

Workgroup Members Present: Doctors Barbara Levy (Acting chair); James Blankenship; Dale Blasier; Doug Leahy; Charles Mabry; Peter Smith; George Williams

I. Introductions and review of Workgroup call purpose

Doctor Levy reviewed the history of the Global Period Workgroup. The Workgroup was established at the April 2013 RUC meeting in response to discussion amongst the RUC concerning whether solutions exist which would more accurately capture physician work in the global period. The charge of the workgroup was to initially consider if the RUC should pursue global period changes and/or a review of services reported within a global bundle. The work related to this primary charge is discussed under the third agenda item.

In the 2015 NPRM, CMS proposed a rationale and timeline to transition all current 090- and 010-day global period surgical services to 000-day global periods. Due to the complex nature of this proposal, AMA staff requested that the Global Period Workgroup review and comment, in an open forum, on the draft RUC comment letter addressing this issue.

II. Discussion of DRAFT RUC Comment letter regarding CMS proposal to transition away from 010- and 090-day global periods.

There was consensus among the Workgroup members that the draft comments as written were well-done and captured many of the complex issues and unintended consequences of the proposal. The Workgroup members were concerned that CMS is proposing to undo 20 years of extremely hard work performed by the RUC, CMS and other stakeholders to properly value services under the current surgical global structure. The members stressed that there are significant issues that CMS must address, including: separately paying for direct practice expense components which reside in the current global bundle, ensuring the redistribution of PLI RVUs does not inappropriately under pay the performing surgeon for the PLI premiums/risk inherent in the service and the impact on the current construct of the multiple procedure reduction rules. Another major concern of the Workgroup was the CMS proposed timeline to finish this review. Providing two years to review the entire set of more than 4,000 010- and 090-day global period surgical codes is unreasonable. Significant time would be needed to survey these new services and to create CPT codes, or other solutions, to pay for the bundled work that is currently being performed in the global and revised the practice expense.

One issue that the Workgroup noted was not currently in the comment letter is that having separately payable post-operative E/M services will cause patients coming back to see their physicians post-operatively to pay co-payments for each visit. There is a concern that by spreading these payments out, the physician's ability to properly manage their patients' status will be eroded because of the potential for them not to return. Furthermore, this proposal will disproportionally affect the sickest patients who will have the highest amount of return visits and therefore the highest co-pays. **AMA staff noted that this concern over patient costs will be included in the comment letter.**

Several Workgroup members noted that even though there are significant concerns and unintended consequences that arise from this proposal, the RUC must directly address the perceived criticisms of the current global period bundled system. The view from some stakeholders is that there is a lack of transparency and accountability under the current bundled global period system because it is difficult to ascertain what services are actually being performed. Furthermore, there are concerns from outside stakeholders, including OIG reports, which come to the conclusion that perhaps some services have more post-operative E/M visits bundled into the global period than are actually performed. Finally, another major criticism is that there are separate standards for E/M work performed separately compared to E/M done in the post-operative period, which is always assumed to be in the non-facility setting and is often reimbursed higher due to the increased practice costs surgeons typically incur.

While the Workgroup members agreed that much of the criticism that CMS lays out in the NPRM is refuted by data and arguments presented in the RUC comment letter, they agreed that there are several reasonable solutions to solve the issue of global period transparency. The Workgroup emphasized that the highest priority should be the collection of a robust data set which captures the physician's actual work in the post-operative period. There are several mechanisms that CMS could use to collect this information.

First, CMS could require the use of 99024 *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure* on al l post-operative follow-up visits. This service is currently status B (bundled) in Medicare and is therefore not paid. However, many hospital-based physician practices are required to use this code on each claim. Several members also indicated that large health systems like Geisinger and the Mayo Clinic require reporting of this service. While the members on the call didn't know whether or not code 99024 was actually being submitted to the insurer, it still offers a collection mechanism that seemingly a large portion of physicians are already utilizing.

Second, CMS could provide a modifier or HCPCS G code to capture when an E/M service is performed in the post-operative period of a surgical code. This method would be more burdensome on the physician as CMS would have to direct physicians in the Final Rule to do so when billing Medicare. Some workgroup members expressed reservation to recommending this option.

Finally, it is currently possible for CMS to review Medicare Part A claims data to determine the length of stay of surgical services performed in the Hospital facility setting. Matching the average length of stay with the post-operative visits in the physician time file will at least give CMS and other stakeholders the opportunity to identify anomalies within the data set that can be looked into further.

The Workgroup made it clear that the ultimate purpose of any of these collection mechanisms would be to identify outliers and develop objective RAW screens based off these data. A reasonable approach would be to collect existing post-operative visit data and then have the RAW, working with CMS, review the data for outliers. This approach is advantageous for two reasons. First and foremost, it doesn't completely undo the hard work incurred since the inception of the RBRVS to properly value surgical services in a bundled global period. It maintains the current global period structure and doesn't cause the myriad unintended consequences of dissolving the current bundled system.

Second, it provides objective data, across a large sample size to determine if a service is currently valued with anomalous visit data. This allows for only the targeted review of services with anomalous data, not a blanket review of all services, with varying degrees of Medicare volume and physician work.

The Global Period Workgroup offers the following recommendations for addition to the RUC Comment Letter:

- **Include a section on the patient access issues resulting from additional patient co-payments for each visit.**
- **Include a section suggesting several mechanisms for CMS to collect objective Medicare claims data related to the post-operative visits actually performed for each service. These mechanisms could include: collecting claims data on 99024 for post-operative E/M services, the creation of a modifier and review of Part A Medicare claims to determine length of stay.**
- **Insist that the RAW process be allowed to develop objective screens to target only those services that appear to be potentially misvalued.**

Furthermore, apart from relying solely on CMS, the RUC should discuss with large hospital/medical systems to determine if a representative sample of data could be obtained that collects the post-op services performed with surgical codes, using CPT code 99024.

III. Previous Global Period Workgroup Recommendation (October 2013)

In the summer of 2013, the Global Period Workgroup met to determine if viable solutions existed to determine a way to more accurately capture the physician work in a service's global period. The Workgroup determined that two potential solutions may exist to provide greater global period transparency. First, a 090-day global service could be reduced to a 000-day. Second, a 090-day global could be reduced to a 010-day global. The Workgroup also discussed several scenarios that would make for good test cases. Since CMS makes final decisions on all global period assignments, the RUC approved the Workgroup's request to solicit specialty societies to nominate services to CMS which may benefit from a change from a 090-day to either a 010- or 000-day global period.

As part of this nomination process, the Workgroup received one request from the American Academy of Neurology (AAN). The specialty society forwarded several chemodenervation codes listed below. Three of these codes (64615, 64616 and 64617) were recently surveyed and the societies deemed that a post-operative visit is not typical for these services. However, CMS made them 010-day global period anyways. **Since the current work valuation for these codes does not include any post-operative visits, the Workgroup recommends that the specialty society and RUC again request that CMS adopt 000-day global periods for these three services.**

CPT Code	Long Descriptor	Global	2013 Utilization	Specialty 1	Specialty 2	Work RVU	Pre	Intra	Imm Post	Total Time
64615	CHEMODENERV MUSC MIGRAINE	010	36,683	NEUROLOGY		1.85	15	15	5	35
64616	CHEMODENERV MUSC NECK DYSTON	010		NEUROLOGY		1.53	15	15	5	35
64617	CHEMODENER MUSCLE LARYNX EMG	010		OTOLARYNGOLOGY		1.90	16	15	5	36

The Workgroup also reviewed two other services in the family, CPT codes 64611 and 64612, but subsequently removed them from the request after discussions with other stakeholders involved in the services.

AMA/Specialty Society RVS Update Committee **Tab 04**
Transcatheter Placement of Carotid Stents
Facilitation Committee #2

Members: Doctors Chad Rubin (Chair), William Donovan, Michael Bishop, Ronald Burd, David Hitzeman, Charles Koopmann, Marc Raphaelson, Peter Smith, George Williams and Jane White

37215 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous including angioplasty, when performed, and radiological supervision and interpretation; with distal embolic protection

The Facilitation Committee members had a detailed conversation about the RUC's concerns over the vignette used in the survey for this procedure. There was some concern during the RUC discussion that the vignette had led the surveyees to perceive 37215 to be more difficult than it actually is. However, this is not the case. The fact that the vignette stated the patient has had radiation therapy is simply to denote that this patient cannot undergo an open procedure (endarterectomy). The specialty explained that this procedure is heavily regulated and in fact has its patient population mandated by CMS through a NCD. Therefore, the information presented in the vignette does not change the nature of the procedure; it simply specifies that the patient would qualify for this procedure under the rigorous CMS guidelines.

With this understanding, the Committee reviewed the physician work involved in CPT code 37215. After careful review, the Committee recommends a direct crosswalk to CPT code 43770 *Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components*) (work RVU= 18.00, intra time= 90 minutes). There was consensus amongst both the Committee and specialty societies that this reference code, with identical intra-service time and analogous post-operative work, provides appropriate relativity to the surveyed code. To support this recommendation, the Committee compared the recommended value to CPT code 27446 *Arthroplasty, knee, condyle and plateau; medial OR lateral compartment* (work RVU= 17.48, intra time= 90 minutes) and agreed that the surveyed code should be valued slightly higher due to greater intensity/complexity. **The Facilitation Committee recommends a work RVU of 18.00, a direct crosswalk to CPT code 43770, for CPT code 37215.**

37216 Transcatheter placement of intravascular stent(s), cervical carotid artery, open or percutaneous including angioplasty, when performed, and radiological supervision and interpretation; without distal embolic protection

The Facilitation Committee also reviewed this service, as it was not discussed by the RUC. The Committee noted that this service is a non-covered service and cannot have survey data due to its inability to be reported. The specialties explained that CPT code 37216 is identical to the work of 37215 but without the distal embolic protection device. The Facilitation Committee was comfortable that the work of these two procedures was identical and deserved identical work RVUs and physician time. Given that 37216 is non-covered by CMS, the Committee recommends a direct crosswalk of both physician work and time to 37215. **The RUC recommends a work RVU of 18.00, lower than the current work value, for CPT code 37216.**

The Facilitation Committee noted that because 37216 received a work RVU and physician time as a result of a direct crosswalk, and due to its non-covered Medicare status, the Committee recommends that CPT code 37216 not be used for future physician work validation.

AMA/Specialty Society RVS Update Committee
Tab 5 Transient Elastography of Liver
Facilitation Committee #3

Members Present: Alan Lazaroff, MD (Chair), Dale Blasier, MD, Scott Collins, MD, Scott Manaker, MD, PhD, William J. Mangold, Jr, MD, Geraldine McGinty, MD, Guy Orangio, MD, Joseph Schlecht, DO, Stanley Stead, MD, and Adam Weinstein, MD

91200 *Liver elastography, mechanically induced shear wave (eg, vibration), without imaging, with interpretation and report*

The Facilitation Committee had a detailed discussion with the specialty societies about the aspects of this new technology service, including the physician work and time involved. The specialty societies initially recommended a work RVU of 0.49, a pre-service time of 7 minutes, an intra-service time of 15 minutes and a post-service time of 5 minutes.

Several Committee members expressed concern with the specialty societies' original pre-time recommendation of 7 minutes, noting that CPT code 71260 *Computed tomography, thorax; with contrast material(s),* also with 15 minutes of intra-time, only has 3 minutes of pre-service time. **Per the Committee's recommendation, the specialty societies agreed to reduce their pre-service time to 3 minutes.**

The specialty societies stated that the typical patient for this service would not require a same day E/M visit. Several Committee members stated that they would accept the total time of 23 minutes if the societies agreed to preclude the reporting of same day E/M visits. **The Facilitation Committee recommends to refercode 91200 to CPT for the inclusion of a parenthetical that would not allow same day E/M visits.**

The Facilitation Committee considered recommendations forwarded from the full RUC, including recommended values and potential crosswalks. The Facilitation Committee identified a crosswalk code forwarded by the full RUC, CPT code 78013 *Thyroid imaging (including vascular flow, when performed);* , which requires similar physician work and pre-, intra- and post-time. The Committee recommends a work RVU of 0.37 for CPT code 91200.

To further validate a work RVU of 0.37, the Committee examined CPT code 95981 *Electronic analysis of implanted neurostimulator pulse generator system (eg, rate, pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient measurements) gastric neurostimulator pulse generator/transmitter; subsequent, without reprogramming* (work RVU= 0.30, intra-time= 10 minutes, total time of 17 minutes) and 93016 *Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or*

pharmacological stress; supervision only, without interpretation and report (work RVU= 0.45, intra-time= 15 minutes, total time of 20 minutes). The Facilitation Committee concurred that these codes appropriately bracket 91200 in respect to the amount and intensity of physician work and both have similar total times relative to 91200.

The Facilitation Committee recommends a work RVU of 0.37, a pre-service time of 3 minutes, an intra-service time of 15 minutes and a post-service time of 5 minutes for CPT code 91200. The Facilitation Committee recommends referral to CPT for the inclusion of a parenthetical that would prohibit same-day E/M visits.